

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11653

CERTIFICATE OF DEATH

11670

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 304	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Horace Middle C. Last Amyx		4. DATE OF DEATH Month August Day 3 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1903
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.	
11. BIRTHPLACE (County & State, or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-03-6734	
17. INFORMANT Lucy Amyx, wife, above (nee Melson)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 Myocardial Infarct IMMEDIATE CAUSE (a) — DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-3 , 19 67 , to 8-3 , 19 67 , that (I) (we) last saw the deceased alive on 8-3 , 19 67 , and that death occurred at 7:47 AM, from causes and on the date stated above.			
22a. SIGNATURE William A. Ellis, Jr.		22b. DATE SIGNED 8-3-67	
22c. PHYSICIAN'S NAME (Type) Dr. Wilbur A. Ellis, Jr.		22d. ADDRESS Medical Center, Salisbury, Maryland	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF 8/7/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Balto., Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13		25a. REC'D BY REGISTRAR DATE AUG 7 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1. Name of patient 2. Age 3. Sex 4. Race 5. Date of admission 6. Date of discharge 7. Date of death 8. Date of autopsy 9. Date of necropsy 10. Date of examination 11. Date of report 12. Date of review 13. Date of final report 14. Date of final review 15. Date of final report 16. Date of final review 17. Date of final report 18. Date of final review 19. Date of final report 20. Date of final review		21. Name of physician 22. Name of hospital 23. Name of department 24. Name of division 25. Name of section 26. Name of subsection 27. Name of subsubsection 28. Name of subsubsubsection 29. Name of subsubsubsubsection 30. Name of subsubsubsubsubsection 31. Name of subsubsubsubsubsubsection 32. Name of subsubsubsubsubsubsubsection 33. Name of subsubsubsubsubsubsubsubsection 34. Name of subsubsubsubsubsubsubsubsubsection 35. Name of subsubsubsubsubsubsubsubsubsubsection 36. Name of subsubsubsubsubsubsubsubsubsubsubsection 37. Name of subsubsubsubsubsubsubsubsubsubsubsubsection 38. Name of subsubsubsubsubsubsubsubsubsubsubsubsubsection 39. Name of subsubsubsubsubsubsubsubsubsubsubsubsubsubsection 40. Name of subsubsubsubsubsubsubsubsubsubsubsubsubsubsubsection	
41. Name of patient 42. Age 43. Sex 44. Race 45. Date of admission 46. Date of discharge 47. Date of death 48. Date of autopsy 49. Date of necropsy 50. Date of examination 51. Date of report 52. Date of review 53. Date of final report 54. Date of final review 55. Date of final report 56. Date of final review 57. Date of final report 58. Date of final review 59. Date of final report 60. Date of final review		61. Name of physician 62. Name of hospital 63. Name of department 64. Name of division 65. Name of section 66. Name of subsection 67. Name of subsubsection 68. Name of subsubsubsection 69. Name of subsubsubsubsection 70. Name of subsubsubsubsubsection 71. Name of subsubsubsubsubsubsection 72. Name of subsubsubsubsubsubsubsection 73. Name of subsubsubsubsubsubsubsubsection 74. Name of subsubsubsubsubsubsubsubsubsection 75. Name of subsubsubsubsubsubsubsubsubsubsection 76. Name of subsubsubsubsubsubsubsubsubsubsubsection 77. Name of subsubsubsubsubsubsubsubsubsubsubsubsection 78. Name of subsubsubsubsubsubsubsubsubsubsubsubsubsection 79. Name of subsubsubsubsubsubsubsubsubsubsubsubsubsubsection 80. Name of subsubsubsubsubsubsubsubsubsubsubsubsubsubsubsection	

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CERTIFICATE OF DEATH

11659

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>yes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>680 W MAIN ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NATHAN</u> Middle <u>Barber</u> Last <u>Barber</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1894</u>		9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ENGLAND NO. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY BARBER</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>1st World War</u>		16. SOCIAL SECURITY NO. <u>1-12-12-12-12</u>		17. INFORMANT Address <u>GWENDOLYN WILLIAMS</u> <u>SALISBURY</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/25</u> , 19 <u>67</u> , to <u>8/31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/31</u> , 19 <u>67</u> , and that death occurred at <u>2:40 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Edward A. Green</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Edward A. Green</u>				22d. ADDRESS <u>PGH</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		23b. DATE THEREOF <u>9/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Middleton Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Columbia MD. Carolina</u>	
24. FUNERAL DIRECTOR <u>Hilda L. West</u>				ADDRESS <u>Salisbury, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 7 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

11660		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		11672	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>151 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>---</u>	
3. NAME OF DECEASED (Type or print) First <u>HERBERT</u> Middle <u>RANDOLPH</u> Last <u>BOULDIN</u>				4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 21, 1902</u>	9. AGE (In years last birthday) yrs. <u>65</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>QUEEN ANNE, Md.</u>	
13. FATHER'S NAME <u>Levi Bouldin</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-16-9042</u>		17. INFORMANT <u>Mrs. Sarah Brown</u> Address <u>Grasonville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of prostate with wide-</u> DUE TO (c) <u>spread metastasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 18</u> , 19 <u>67</u> , to <u>August 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>August 16</u> , 19 <u>67</u> , and that death occurred at <u>11:28 A</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>W. Heald</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Deer's Head State Hospital, Salisbury, Md.</u>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROBINSON'S CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>GRASONVILLE - QUEEN ANNE Md.</u>	
24. FUNERAL DIRECTOR <u>Charles H. Darby</u>		ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 22 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1901.

REPORT OF THE

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11661

CERTIFICATE OF DEATH

11678

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u> <u>221</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>721 Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>HAZEL W. BRADLEY</u>			4. DATE OF DEATH Month <u>AUG</u> Day <u>8</u> Year <u>1967</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 6, 1912</u> <u>55</u> yrs.		9. AGE (In years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>duPont</u>		11. BIRTHPLACE (County & State or foreign country) <u>PA.</u>	
13. FATHER'S NAME <u>JAMES B. WARREN</u>			14. MOTHER'S MAIDEN NAME <u>Mildred E. Reynolds</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-3935</u>		17. INFORMANT <u>W. Cooper Bradley</u> Address <u>Sharptown Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1750</u> IMMEDIATE CAUSE (a) <u>Carcinomatous - primary ovary</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from <u>7-19</u> , 19 <u>67</u> , to <u>8-5</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>8-5</u> , 19 <u>67</u> , and that death occurred at <u>3:50 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Neuman W. Tine</u>				22b. DATE SIGNED <u>8-5-67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Aug. 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Friemont</u>	
23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <u>Sharptown</u> <u>Wicomico Md.</u>					
24. FUNERAL DIRECTOR <u>Neuman Funeral Home</u>		ADDRESS <u>Sharptown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

11662

CERTIFICATE OF DEATH

11674

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 Day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 508 S. Division St.,	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALBERT Middle HYLAS Last BRITTINGHAM		4. DATE OF DEATH Month 8 Day 2 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1899
9. AGE (In years last birthday) yrs. 67		IF UNDER 1 YEAR Months 2 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Accountant Del. Power & Light Co.		10b. KIND OF BUSINESS OR INDUSTRY Wicomico, Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Brittingham		14. MOTHER'S MAIDEN NAME Emma Parsons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-10-9657-A	
17. INFORMANT Mrs. Laura C. Brittingham		Address See Sec 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus with metastases DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 wks -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/1 , 19 67 , to 8/2 , 19 67 , that (I) (we) last saw the deceased alive on 8/2 19 67 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE William P. Sadler M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/4/67
22c. PHYSICIAN'S NAME (Type) WILLIAM P. SADLER M.D.		22d. ADDRESS MEDICAL CTR. SALISBURY, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-4-1967	23c. NAME OF CEMETERY OR CREMATORY Parson Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR Hill Funeral Home ADDRESS Salisbury, Maryland		25a. REC'D BY REGISTRAR DATE AUG 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

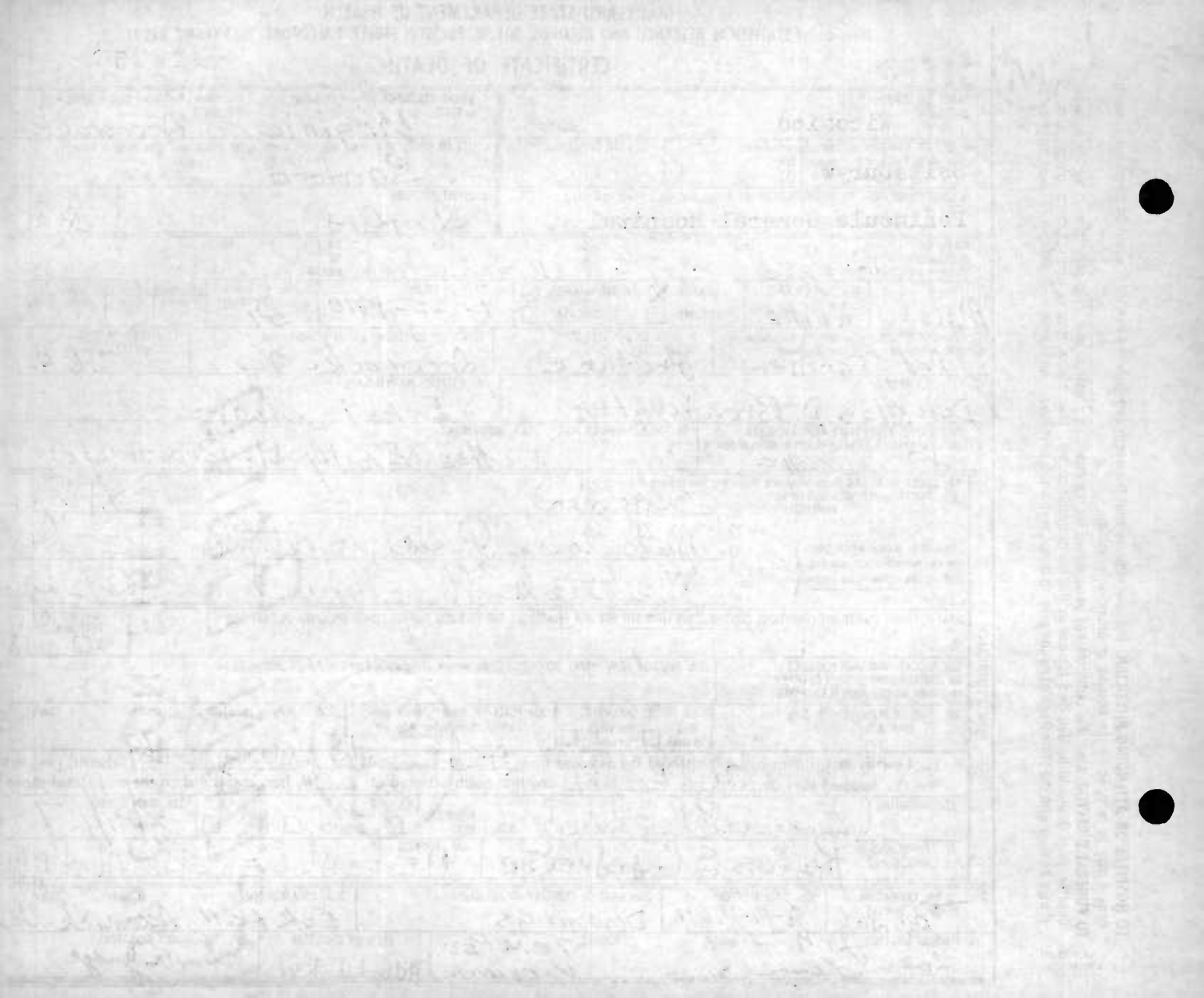
11675

11663

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Accomack	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sanford
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Sanford	
3. NAME OF DECEASED (Type or print) Willard Moore Broadwater		4. DATE OF DEATH August 7 1967	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-1910
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Produce	
11. BIRTHPLACE (County & State, or foreign country) Accomack - Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Douglas D. Broadwater		14. MOTHER'S MAIDEN NAME Ethel Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No none		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Emily M. Broadwater		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Metastases, Bone, multiple DUE TO (c) Multiple Myeloma		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs 2 + yrs 2 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 67 , to Aug , 19 67 , that (I) (we) last saw the deceased alive on Aug 6 19 67 , and that death occurred at 4:30 AM, from causes and on the date stated above.			
22a. SIGNATURE Rufus S. Gardner Jr		22b. DATE SIGNED 8/7/67	
22c. PHYSICIAN'S NAME (Type) RUFUS S. GARDNER JR		22d. ADDRESS MEDICAL CENTER, SALISBURY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-9-1967	23c. NAME OF CEMETERY OR CREMATORY Downings	23d. LOCATION (City or Town) (County) (State) Oak Hill, Accomack - Va
24. FUNERAL DIRECTOR J. N. Fat		25a. REC'D BY REGISTRAR AUG 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1b & d Film #G392 9/18/67 pn

CERTIFICATE OF DEATH

11664

11876

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardela</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARDELA Spring.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. #1</u>		d. STREET ADDRESS <u>R.F. DAL Box 149</u>	
3. NAME OF DECEASED (Type or print) <u>RAYMOND ELZEY BROWN</u>		4. DATE OF DEATH <u>8</u> <u>29</u> <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1910</u>
9. AGE (In years lost birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR <u>22-1</u> IF UNDER 24 HRS. <u>19</u> <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Bus Contractor</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Elzey Brown</u>		14. MOTHER'S MAIDEN NAME <u>Vicie Ann Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Thelma I. Brown</u>		Address <u>R.F. DAL Box 149 Mardela Spring</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Coronary failure</u> DUE TO (b) <u>Arteriosclerotic Heart Dis.</u> DUE TO (c) <u>5 yrs +</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Myeloma</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>67</u> , to <u>death</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>8/27</u> 19 <u>67</u> , and that death occurred at <u>4 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>E. M. LAR MORE</u>		22b. DATE SIGNED <u>8/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. M. LAR MORE</u>		22d. ADDRESS <u>DELMAR DEL.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-2-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Iron Methodist</u>		23d. LOCATION (City or town) (County) (State) <u>Sharpton W. Co Md.</u>	
24. FUNERAL DIRECTOR <u>Barbara B. Jolley</u>		25a. RECEIVED BY REGISTRAR <u>SEP 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11665					11677				
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 4 mths d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wicomico Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 725 Spring Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ettore First Middle Last Caprioglio			4. DATE OF DEATH Aug. 27 Month Day Year 19 67						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 2, 1899		9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurateur			10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) Milan, Italy			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unk					14. MOTHER'S MAIDEN NAME unk				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unk			16. SOCIAL SECURITY NO. unk		17. INFORMANT Mrs. Mildred L. Caprioglio, Salisbury, Md. Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 5271 DUE TO (b) cor pulmonale Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) pulmonary emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 mo yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8/7 , 19 67 , to 8/27 , 19 67 , that (I) (we) last saw the deceased alive on 8/26 , 19 67 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE Cathy Bendley					22b. DATE SIGNED 9/2/67			22c. PHYSICIAN'S NAME (Type) LeCompte Funeral Service, Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Aug 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Vienna Cemetery			23d. LOCATION (City, town or county) (State) Vienna, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland ADDRESS					25a. REC'D BY REGISTRAR SEP 7 1967 DATE		25b. REGISTRAR'S SIGNATURE Charles J. J...		

11666

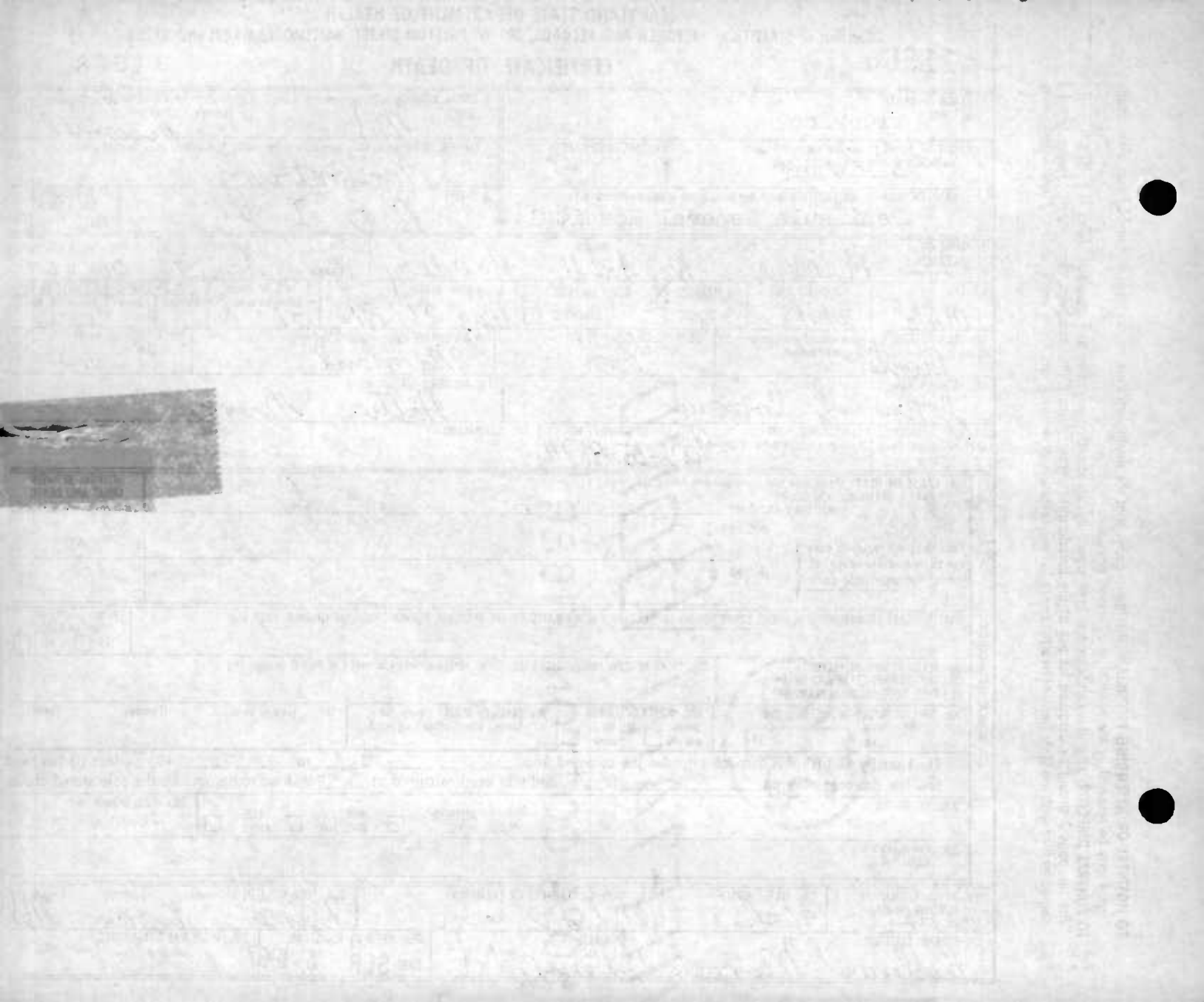
CERTIFICATE OF DEATH

11678

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Parsonsbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R & I</u>	
3. NAME OF DECEASED (Type or print) <u>MARVIN</u> First <u>WOODROW</u> Middle <u>Cordrey</u> Last		4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1916</u> 9. AGE (In years last birthday) <u>51</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wood</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>John S. Cordrey</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>221-05-9870</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - originally from</u> DUE TO (b) <u>@ lung</u> DUE TO (c) <u>4 mos -</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-23</u> , 19 <u>67</u> , to <u>8-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-30</u> , 19 <u>67</u> , and that death occurred at <u>5:28</u> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <u>W. W. W.</u>		22b. DATE SIGNED <u>8-30-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Melrose Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Delmar</u> <u>Wicomico</u> <u>MD</u>
24. FUNERAL DIRECTOR <u>William M. Marshall</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 5 1967</u>	
ADDRESS <u>Delmar, Del.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 19. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

11667

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11679

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 50 & Hebron Road		d. STREET ADDRESS 7836 Hillsway Ave.	
3. NAME OF DECEASED (Type or print) NANCY LEA CORRIGAN		4. DATE OF DEATH Month 8 Day 25 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-46
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 20 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James J. Corrigan		14. MOTHER'S MAIDEN NAME Thelma D. Hinz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. James J. Corrigan-- Same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 8164 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Third degree burns (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto struck from behind by another vehicle.	
20c. TIME OF INJURY Month, Day, Year 9 Hour 300 p.m. 8-25-67		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 50 & Hebron Rd.		20f. (City or town) (County) (State) Wicomico, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED August 26, 1967	
EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/29/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Leonard Ruck, Inc., Baltimore, Md.		25a. REC'D BY REGISTRAR AUG 28 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

ANNUAL REPORT OF THE
BUREAU OF PLANT INDUSTRY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

11668		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		11680	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3yrs. 3mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>91 Deer's Head State Hospital</u>			d. STREET ADDRESS <u>204 Center Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ida Frances Crockett</u>			4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1876</u>		9. AGE (In years last birthday) <u>91</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Somerset County, Maryland</u>	
13. FATHER'S NAME <u>William Dize</u>			14. MOTHER'S MAIDEN NAME <u>Rebecca Stewart</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mabel C. Humphreys (Daughter)</u> <u>204 Center Street, Salisbury, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4501 Arteriosclerotic gangrene of left lower extremity 1 wk</u> DUE TO (b) <u>Thrombosis of iliac artery & abdominal aorta 4 yrs</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adenocarcinoma of cecum & Transverse Colon</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>May 27, 1964</u> to <u>August 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 20, 1967</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>A. C. Mitchell</u>		22b. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M.D.</u>		22c. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	
23d. LOCATION (City or Town) <u>Salisbury, Maryland</u>		23e. REC'D BY REGISTRAR <u>Charles Judge</u>			
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11669

11681

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tyaskin, R.F.D. Lifetime</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tyaskin, R.F.D. 221</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Mary L. Dashiell</u>				4. DATE OF DEATH Month <u>8</u> Day <u>-3</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/28/1894</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Hillary Robertson</u>				14. MOTHER'S MAIDEN NAME <u>Carrie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Laura Jasper</u>				Address <u>Philadelphia Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 3327 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/26/67</u> to <u>8/3/67</u> , that (I) (we) last saw the deceased alive on <u>8/3/67</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Earl Beardsley</u>				22b. DATE <u>8/4/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Earl Beardsley</u>	
22d. ADDRESS <u>Adelphi, Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE <u>8/4/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Family Cem.</u>		23d. LOCATION (City, town or county) (State) <u>White Haven, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Messick</u>				24b. ADDRESS <u>Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. DATE <u>AUG 8 1967</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Central American

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CERTIFICATE OF DEATH

11082

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Jersey Rd.	
3. NAME OF DECEASED (Type or print) Reginald First Wayde Middle DAVIS Last		4. DATE OF DEATH Month AUGUST Day 4 Year 1967	
5. SEX MALE	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/28/1967
9. AGE (In years lost birthday) yrs. 7		IF UNDER 1 YEAR Months 7 Days 4	IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ralph Davis	
14. MOTHER'S MAIDEN NAME Mildred Washington		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mildred Davis Address Jersey Rd. Salis. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (Presumptive) Subarachnoid Hemorrhage 7605 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (WT 1405 gms) (c) approx 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 7/28 , 19 67 , to 8/4 , 19 67 , that (1) (we) last saw the deceased alive on 8/4 , 19 67 and that death occurred at 1:50 P.M., from causes and on the date stated above.			
22a. SIGNATURE Alfred C. Keller		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Medical Center - Salisbury Md.		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/6/1967	23c. NAME OF CEMETERY OR CREMATORY Green Arces Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md.
24. FUNERAL DIRECTOR Chitra F. Stewart		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Salis - Md.		DATE AUG 8 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

STATEMENT OF DEATH

WISCONSIN

WHITE

born with hand and foot (L) (R) (L) (R)
(L) (R) (L) (R) (L) (R) (L) (R)

APR 2 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 35 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS 222 Maryland Avenue	
3. NAME OF DECEASED (Type or print) First MATTIE Middle JANE Last DENNIS		4. DATE OF DEATH Month 8 Day 28 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 10, 1876
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		9b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEMUEL R. MELVIN		14. MOTHER'S MAIDEN NAME MARY ANN TIMMONS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MRS ROBERT ROGERS SALISBURY MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 1420 DUE TO (b) Malignancy of right parotid gland DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 days 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 24, 1967 , to August 28, 1967 , that (I) (we) last saw the deceased alive on August 28, 1967 , and that death occurred at 7:48 PM , from causes and on the date stated above.			
22a. SIGNATURE A. C. Mitchell		22b. DATE SIGNED 8/28/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/31/1967	23c. NAME OF CEMETERY OR CREMATORY EVERGREEN	23d. LOCATION (City or Town) (County) (State) BERLIN WOR MD
24. FUNERAL DIRECTOR Anna A. Buibage Bulin and		25a. REC'D BY REGISTRAR SEP 1 1967	25b. REGISTRAR'S SIGNATURE Charles J. J...

Page 3

STATEMENT OF CLAIM

No.	Name of Claimant	Address	Description of Claim
1	John Doe	123 Main St, City, State	Acres of land in Section 1, Township 1N, Range 1E.
2	Jane Smith	456 Oak Ave, City, State	Acres of land in Section 2, Township 1N, Range 1E.
3	Robert Brown	789 Elm St, City, State	Acres of land in Section 3, Township 1N, Range 1E.
4	William White	101 Pine St, City, State	Acres of land in Section 4, Township 1N, Range 1E.
5	Elizabeth Black	202 Cedar St, City, State	Acres of land in Section 5, Township 1N, Range 1E.
6	James Green	303 Birch St, City, State	Acres of land in Section 6, Township 1N, Range 1E.
7	Mary Johnson	404 Spruce St, City, State	Acres of land in Section 7, Township 1N, Range 1E.
8	Charles Wilson	505 Willow St, City, State	Acres of land in Section 8, Township 1N, Range 1E.
9	Thomas Moore	606 Ash St, City, State	Acres of land in Section 9, Township 1N, Range 1E.
10	Anna Taylor	707 Hickory St, City, State	Acres of land in Section 10, Township 1N, Range 1E.
11	George Hall	808 Sycamore St, City, State	Acres of land in Section 11, Township 1N, Range 1E.
12	Patricia King	909 Magnolia St, City, State	Acres of land in Section 12, Township 1N, Range 1E.
13	Richard Scott	1010 Poplar St, City, State	Acres of land in Section 13, Township 1N, Range 1E.
14	Susan Adams	1111 Walnut St, City, State	Acres of land in Section 14, Township 1N, Range 1E.
15	Donald Baker	1212 Chestnut St, City, State	Acres of land in Section 15, Township 1N, Range 1E.
16	Barbara Miller	1313 Elm St, City, State	Acres of land in Section 16, Township 1N, Range 1E.
17	Edward Davis	1414 Oak Ave, City, State	Acres of land in Section 17, Township 1N, Range 1E.
18	Carol Evans	1515 Pine St, City, State	Acres of land in Section 18, Township 1N, Range 1E.
19	Frank Phillips	1616 Cedar St, City, State	Acres of land in Section 19, Township 1N, Range 1E.
20	Linda Young	1717 Birch St, City, State	Acres of land in Section 20, Township 1N, Range 1E.
21	Robert King	1818 Spruce St, City, State	Acres of land in Section 21, Township 1N, Range 1E.
22	Michelle Wright	1919 Willow St, City, State	Acres of land in Section 22, Township 1N, Range 1E.
23	Steven Lopez	2020 Ash St, City, State	Acres of land in Section 23, Township 1N, Range 1E.
24	Kimberly Hill	2121 Hickory St, City, State	Acres of land in Section 24, Township 1N, Range 1E.
25	Christopher Scott	2222 Magnolia St, City, State	Acres of land in Section 25, Township 1N, Range 1E.
26	Angela Green	2323 Poplar St, City, State	Acres of land in Section 26, Township 1N, Range 1E.
27	Gregory Adams	2424 Walnut St, City, State	Acres of land in Section 27, Township 1N, Range 1E.
28	Deborah Baker	2525 Chestnut St, City, State	Acres of land in Section 28, Township 1N, Range 1E.
29	Timothy Miller	2626 Elm St, City, State	Acres of land in Section 29, Township 1N, Range 1E.
30	Christina Davis	2727 Oak Ave, City, State	Acres of land in Section 30, Township 1N, Range 1E.
31	Jeffrey Evans	2828 Pine St, City, State	Acres of land in Section 31, Township 1N, Range 1E.
32	Stephanie Phillips	2929 Cedar St, City, State	Acres of land in Section 32, Township 1N, Range 1E.
33	Brandon Young	3030 Birch St, City, State	Acres of land in Section 33, Township 1N, Range 1E.
34	Nicole King	3131 Spruce St, City, State	Acres of land in Section 34, Township 1N, Range 1E.
35	Justin Wright	3232 Willow St, City, State	Acres of land in Section 35, Township 1N, Range 1E.
36	Brittany Lopez	3333 Ash St, City, State	Acres of land in Section 36, Township 1N, Range 1E.
37	Adam Hill	3434 Hickory St, City, State	Acres of land in Section 37, Township 1N, Range 1E.
38	Heather Scott	3535 Magnolia St, City, State	Acres of land in Section 38, Township 1N, Range 1E.
39	Jonathan Green	3636 Poplar St, City, State	Acres of land in Section 39, Township 1N, Range 1E.
40	Kyle Adams	3737 Walnut St, City, State	Acres of land in Section 40, Township 1N, Range 1E.
41	Victoria Baker	3838 Chestnut St, City, State	Acres of land in Section 41, Township 1N, Range 1E.
42	Benjamin Miller	3939 Elm St, City, State	Acres of land in Section 42, Township 1N, Range 1E.
43	Rebecca Davis	4040 Oak Ave, City, State	Acres of land in Section 43, Township 1N, Range 1E.
44	Ethan Evans	4141 Pine St, City, State	Acres of land in Section 44, Township 1N, Range 1E.
45	Chloe Phillips	4242 Cedar St, City, State	Acres of land in Section 45, Township 1N, Range 1E.
46	Lucas Young	4343 Birch St, City, State	Acres of land in Section 46, Township 1N, Range 1E.
47	Olivia King	4444 Spruce St, City, State	Acres of land in Section 47, Township 1N, Range 1E.
48	Isaac Wright	4545 Willow St, City, State	Acres of land in Section 48, Township 1N, Range 1E.
49	Grace Lopez	4646 Ash St, City, State	Acres of land in Section 49, Township 1N, Range 1E.
50	Henry Hill	4747 Hickory St, City, State	Acres of land in Section 50, Township 1N, Range 1E.
51	Abigail Scott	4848 Magnolia St, City, State	Acres of land in Section 51, Township 1N, Range 1E.
52	Leo Green	4949 Poplar St, City, State	Acres of land in Section 52, Township 1N, Range 1E.
53	Isabella Adams	5050 Walnut St, City, State	Acres of land in Section 53, Township 1N, Range 1E.
54	Maxwell Baker	5151 Chestnut St, City, State	Acres of land in Section 54, Township 1N, Range 1E.
55	Evelyn Miller	5252 Elm St, City, State	Acres of land in Section 55, Township 1N, Range 1E.
56	Julian Davis	5353 Oak Ave, City, State	Acres of land in Section 56, Township 1N, Range 1E.
57	Clara Evans	5454 Pine St, City, State	Acres of land in Section 57, Township 1N, Range 1E.
58	Robert Phillips	5555 Cedar St, City, State	Acres of land in Section 58, Township 1N, Range 1E.
59	Charlotte Young	5656 Birch St, City, State	Acres of land in Section 59, Township 1N, Range 1E.
60	Samuel King	5757 Spruce St, City, State	Acres of land in Section 60, Township 1N, Range 1E.
61	Amelia Wright	5858 Willow St, City, State	Acres of land in Section 61, Township 1N, Range 1E.
62	Benjamin Lopez	5959 Ash St, City, State	Acres of land in Section 62, Township 1N, Range 1E.
63	Harriet Hill	6060 Hickory St, City, State	Acres of land in Section 63, Township 1N, Range 1E.
64	William Scott	6161 Magnolia St, City, State	Acres of land in Section 64, Township 1N, Range 1E.
65	Elizabeth Green	6262 Poplar St, City, State	Acres of land in Section 65, Township 1N, Range 1E.
66	James Adams	6363 Walnut St, City, State	Acres of land in Section 66, Township 1N, Range 1E.
67	Margaret Baker	6464 Chestnut St, City, State	Acres of land in Section 67, Township 1N, Range 1E.
68	Charles Miller	6565 Elm St, City, State	Acres of land in Section 68, Township 1N, Range 1E.
69	Frances Davis	6666 Oak Ave, City, State	Acres of land in Section 69, Township 1N, Range 1E.
70	John Evans	6767 Pine St, City, State	Acres of land in Section 70, Township 1N, Range 1E.
71	William Phillips	6868 Cedar St, City, State	Acres of land in Section 71, Township 1N, Range 1E.
72	Mary Young	6969 Birch St, City, State	Acres of land in Section 72, Township 1N, Range 1E.
73	Robert King	7070 Spruce St, City, State	Acres of land in Section 73, Township 1N, Range 1E.
74	Elizabeth Wright	7171 Willow St, City, State	Acres of land in Section 74, Township 1N, Range 1E.
75	James Lopez	7272 Ash St, City, State	Acres of land in Section 75, Township 1N, Range 1E.
76	Margaret Hill	7373 Hickory St, City, State	Acres of land in Section 76, Township 1N, Range 1E.
77	Charles Scott	7474 Magnolia St, City, State	Acres of land in Section 77, Township 1N, Range 1E.
78	Frances Green	7575 Poplar St, City, State	Acres of land in Section 78, Township 1N, Range 1E.
79	John Adams	7676 Walnut St, City, State	Acres of land in Section 79, Township 1N, Range 1E.
80	William Baker	7777 Chestnut St, City, State	Acres of land in Section 80, Township 1N, Range 1E.
81	Mary Miller	7878 Elm St, City, State	Acres of land in Section 81, Township 1N, Range 1E.
82	Robert Davis	7979 Oak Ave, City, State	Acres of land in Section 82, Township 1N, Range 1E.
83	Elizabeth Evans	8080 Pine St, City, State	Acres of land in Section 83, Township 1N, Range 1E.
84	James Phillips	8181 Cedar St, City, State	Acres of land in Section 84, Township 1N, Range 1E.
85	Margaret Young	8282 Birch St, City, State	Acres of land in Section 85, Township 1N, Range 1E.
86	Charles King	8383 Spruce St, City, State	Acres of land in Section 86, Township 1N, Range 1E.
87	Frances Wright	8484 Willow St, City, State	Acres of land in Section 87, Township 1N, Range 1E.
88	John Lopez	8585 Ash St, City, State	Acres of land in Section 88, Township 1N, Range 1E.
89	William Hill	8686 Hickory St, City, State	Acres of land in Section 89, Township 1N, Range 1E.
90	Mary Scott	8787 Magnolia St, City, State	Acres of land in Section 90, Township 1N, Range 1E.
91	Robert Green	8888 Poplar St, City, State	Acres of land in Section 91, Township 1N, Range 1E.
92	Elizabeth Adams	8989 Walnut St, City, State	Acres of land in Section 92, Township 1N, Range 1E.
93	James Baker	9090 Chestnut St, City, State	Acres of land in Section 93, Township 1N, Range 1E.
94	Margaret Miller	9191 Elm St, City, State	Acres of land in Section 94, Township 1N, Range 1E.
95	Charles Davis	9292 Oak Ave, City, State	Acres of land in Section 95, Township 1N, Range 1E.
96	Frances Evans	9393 Pine St, City, State	Acres of land in Section 96, Township 1N, Range 1E.
97	John Phillips	9494 Cedar St, City, State	Acres of land in Section 97, Township 1N, Range 1E.
98	William Young	9595 Birch St, City, State	Acres of land in Section 98, Township 1N, Range 1E.
99	Mary King	9696 Spruce St, City, State	Acres of land in Section 99, Township 1N, Range 1E.
100	Robert Wright	9797 Willow St, City, State	Acres of land in Section 100, Township 1N, Range 1E.

11672

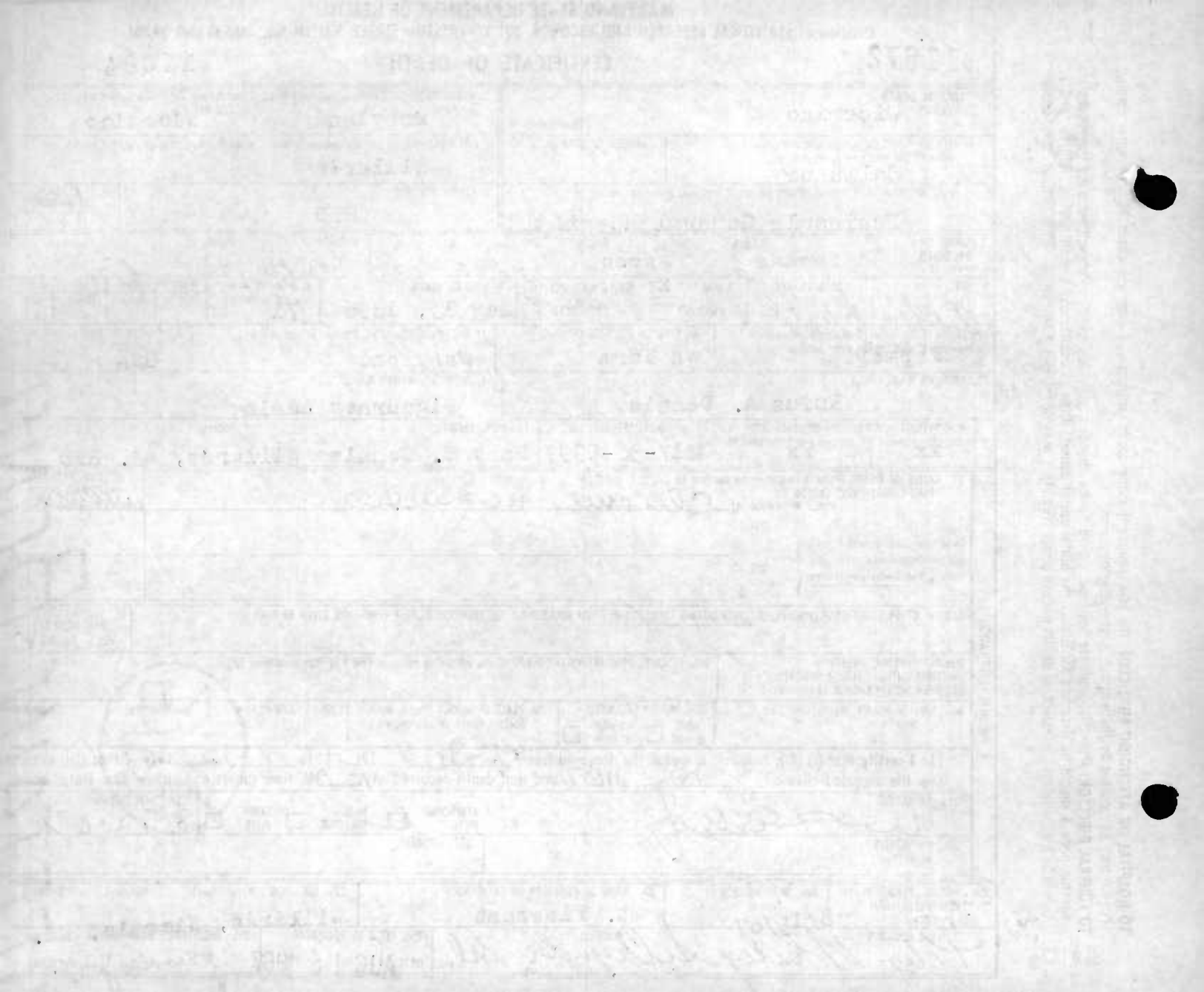
CERTIFICATE OF DEATH

11684

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Willards	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle James Last Dennis		4. DATE OF DEATH Month August Day 12 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1896
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rufus A. Dennis		14. MOTHER'S MAIDEN NAME Sigourney Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) XX		16. SOCIAL SECURITY NO. 217-36-0997	
17. INFORMANT Mary E. Dennis		Address Willards, Md. RFD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic neoplasms DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 592X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-30 , 19 67 , to 8-12 , 19 67 , that (I) (we) lost saw the deceased alive on 8-12 , 19 67 , and that death occurred at 10 AM , from causes on and on the date stated above.			
22a. SIGNATURE W. S. Ellis		22b. DATE SIGNED 8-12-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/15/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant	23d. LOCATION (City or Town) (County) (State) Willards, Wicomico, Md.
24. FUNERAL DIRECTOR John W. Halley Salisbury, Del.		25a. REC'D BY REGISTRAR AUG 15 1967	
		25b. REGISTRAR'S SIGNATURE John Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11673 CERTIFICATE OF DEATH 11685

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 125 Onley Road				d. STREET ADDRESS 125 Onley Road			
3. NAME OF DECEASED (Type or print) First HARRY Middle HOLLOWAY Last DERICKSON				4. DATE OF DEATH Month August Day 8 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1902	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber				10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (County & State, or foreign country) Roxanna, Delaware	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James L. Derickson				14. MOTHER'S MAIDEN NAME Luvenia B. Hickman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 214-10-9349		17. INFORMANT Mrs. Clara Belle Derickson (Wife) 125 Onley Road, Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov. 1967 to Aug 8, 1967 , that (I) (we) last saw the deceased alive on Aug 6, 1967 , and that death occurred at 7:00 M, from the causes and on the date stated above.							
22a. SIGNATURE William D. Gray				22b. DATE SIGNED August 10, 1967			
22c. PHYSICIAN'S NAME (Type) Dr. William D. Gray				22d. ADDRESS 334 Camden Ave., Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 10, 1967		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25. REC'D BY REGISTRAR AUG 11 1967			
25b. REGISTRAR'S SIGNATURE Charles Judge							

CERTIFICATE OF DEATH

1. Name of Deceased: *John A. Smith*
2. Date of Death: *March 22, 1967*
3. Place of Death: *123 Oak Street, Baltimore, Maryland*
4. Cause of Death: *Heart Disease*
5. Age at Death: *65*
6. Sex: *Male*
7. Race: *White*
8. Marital Status: *Married*
9. Occupation: *Teacher*
10. Signature of Physician: *[Signature]*
11. Signature of Registrar: *[Signature]*
12. Date of Registration: *March 25, 1967*
13. Place of Registration: *Baltimore, Maryland*

11674

CERTIFICATE OF DEATH

11686

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Md.		c. LENGTH OF STAY IN lb 7mos. 22days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital			d. STREET ADDRESS 405 Pine Bluff Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Clarence William Dickey			4. DATE OF DEATH Month August Day 6 Year 1967		
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1892		9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Du Pont Co.		10b. KIND OF BUSINESS OR INDUSTRY Executive		11. BIRTHPLACE (County & State, or foreign country) Wilmington, Del.	
13. FATHER'S NAME Lewis Dickey			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Clarence W. Dickey, Salisbury	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1992 IMMEDIATE CAUSE (a) Carcinomatosis - primary undetected DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus, Generalized Arteriosclerosis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/14/66 , 19 66 to 8/6 , 19 67 , that (I) (we) last saw the deceased alive on August 6 , 19 67 , and that death occurred at 12:45 PM , from causes and on the date stated above.					
22a. SIGNATURE A. C. Mitchell		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/6/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8-10-67		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory	
				23d. LOCATION (City or Town) (County) (State) Wilmington, N. Castle, Del	
24. FUNERAL DIRECTOR Levin R. Wilson		ADDRESS Primers Anne		25a. REC'D BY REGISTRAR DATE AUG 11 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in ~~any~~ event, within 72 hours after death.

CHARTER OF OATH



Continued to former number 119

Public Health, Sanitary Administration

2/2/21

W. C. McIntosh

W. C. McIntosh, Secretary, W. C. McIntosh, Secretary

11675

CERTIFICATE OF DEATH

11687

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>22.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>615 Lake St. S</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Elizabeth</u> Last <u>FARLOW</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-FRI</u>
9. AGE (In years last birthday) <u>46</u> YRS.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Hoge</u>	
14. MOTHER'S MAIDEN NAME <u>MARY Johnson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Pauline Bailey</u> Address <u>412 Stewart Pl. Salisbury</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Territorial</u> DUE TO <u>153.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Long Bow Obstruction</u> DUE TO (c) <u>Carcinoma of Sigmoid Colon</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>67</u> to <u>8/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/21</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward A. Benson</u>		22b. DATE SIGNED <u>8/20/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-1-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREEN ACRES</u>	23d. LOCATION (City or Town) (County) (State) <u>SALISBURY Wic. Md.</u>
24. FUNERAL DIRECTOR <u>Loretta B. Jolley</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>			

2
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

80

3

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11676

CERTIFICATE OF DEATH

11688

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Del</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> 46-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>905 State St.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELLA</u> Last <u>Figgis</u>		4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4 1883</u>
9. AGE (In years last birthday) <u>84</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State for foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George W. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Olevia Morris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>221-03-1155</u>	
17. INFORMANT <u>Mrs Herman White</u>		Address <u>Delmar Del</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-28</u> , 19 <u>67</u> , to <u>8-14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-14</u> , 19 <u>67</u> , and that death occurred at <u>5:15</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>William M. Moray</u>		22b. DATE SIGNED <u>8-16-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/17/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen</u>		23d. LOCATION (City or Town) (County) (State) <u>Delmar Sussex Del</u>	
24. FUNERAL DIRECTOR <u>William M. Moray</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 18 1967</u>	
ADDRESS <u>Delmar Del</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF ORIGIN

1911



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11677

11689

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN b. <u>Adm. in 1 d 7/8/67</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>118 Mt. Hermon Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>SALLY</u> Middle <u>MARTHA</u> Last <u>FOOKS</u>				4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1967</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 24, 1905</u>		9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shirt Company</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Newark, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edward King Jones</u>						14. MOTHER'S MAIDEN NAME <u>Olivia Whittington</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-10-8306</u>				17. INFORMANT <u>Mr. Donald R. Fooks (Son)</u> Address <u>11451 Lockwood Drive, Silver Spring, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Sarcoma</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Sarcoma Esophagus</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>7/17</u>, 19<u>67</u> to <u>8-11</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>8/17</u>, 19<u>67</u>, and that death occurred at <u>1</u> A.M. from the causes and on the date stated above.															
22a. SIGNATURE <u>John T. Bulkeley</u> M.D.						22b. DATE SIGNED <u>August 17/1967</u>									
22c. PHYSICIAN'S NAME (Type) <u>Dr. John T. Bulkeley</u>						22d. ADDRESS <u>S. Salisbury Blvd. & Pine Bluff Rd. Salisbury, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>August 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>				23d. LOCATION (City, town or county) <u>Salisbury, Maryland</u> (State) <u> </u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>DATE AUG 18 1967</u>									

11678

CERTIFICATE OF DEATH

11680

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY in 1b 129 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.				d. STREET ADDRESS R.D.#4, Snow Hill Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ida Middle Mae Last Goffigon				4. DATE OF DEATH Month 8 Day 12 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1888		9. AGE (In years lost birthday) yrs. 78	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Dickinson				14. MOTHER'S MAIDEN NAME Esther Jane Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-3514		17. INFORMANT Mrs. Margaret G. Smith (Daughter) R.D.#4, Snow Hill Road, Salisbury, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arteriosclerosis Generalized DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 Months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A				
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/5, 1967 to 8/12, 1967 , that (I) (we) last saw the deceased alive on 8/12, 1967 , and that death occurred at 8:45 PM , from causes and on the date stated above.							
22a. SIGNATURE L. V. Maldve				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/14/67	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DATE AUG 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		John A. Dickinson	
Sex		Male	
Age		67	
Date of Birth		1872	
Place of Birth		New York	
Cause of Death		Heart Disease	
Date of Death		1939	
Place of Death		New York	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		1939	
Place of Registration		New York	

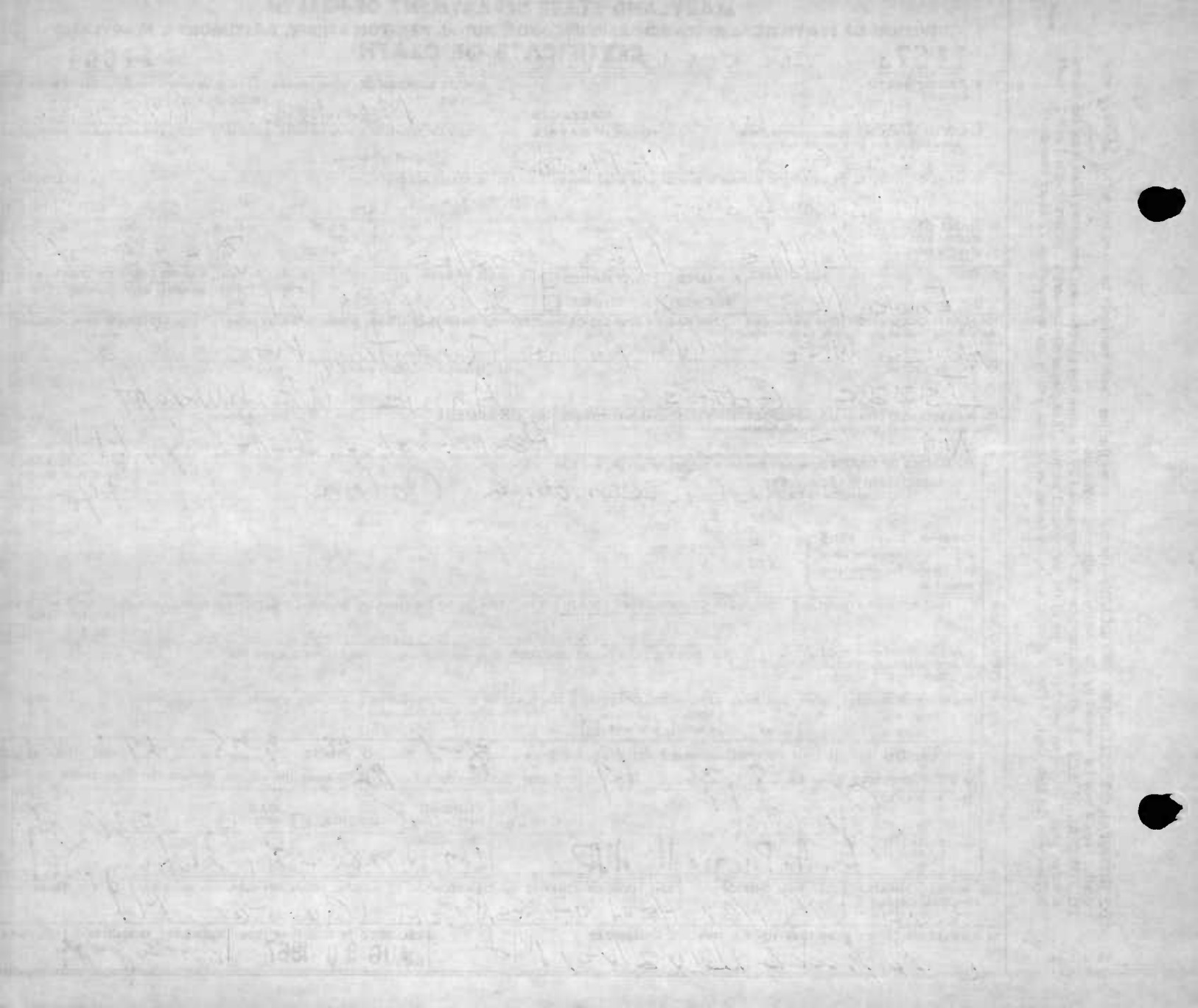
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Titen please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item #2c & d Film #3572 975/67 ph											
11679 11691											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					
c. LENGTH OF STAY IN lb <u>14 Months</u>						d. STREET ADDRESS <u>Wilson Lane</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wilson Lane</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Mae</u> Last <u>Goslee</u>						4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/6/1886</u>		9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>14</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		13. BIRTHPLACE (County & State, or foreign country) <u>Quantico, Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1538</u>	
17. FATHER'S NAME <u>Isaac Gates</u>						18. MOTHER'S MAIDEN NAME <u>Annie Wainwright</u>					
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						20. SOCIAL SECURITY NO. <u>1538</u>					
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Colon</u> 1538 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>1538</u> (a), stating the underlying cause last. DUE TO (c) <u>1538</u>						22. INTERVAL BETWEEN ONSET AND DEATH <u>14</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
25. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		26. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town)		29. (County)		30. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-1</u> to <u>8-25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-25</u> , 19 <u>67</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.											
22. SIGNATURE <u>E. A. Purnell</u>						23. DATE SIGNED <u>28 Aug 67</u>					
24. PHYSICIAN'S NAME (Type) <u>E. A. Purnell, MD.</u>						25. ADDRESS <u>622 W. Main St., Salisbury, Md.</u>					
26. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		27. DATE THEREOF <u>8/29/67</u>		28. NAME OF CEMETERY OR CREMATORY <u>Heard of Creek Cem.</u>		29. LOCATION (City, town or county) <u>Quantico, Md.</u>		30. (State) <u>Md.</u>		31. (Country) <u>U.S.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. B. Purnell</u>						25. ADDRESS <u>1215 W. Main St., Salisbury, Md.</u>					
26. REC'D BY REGISTRAR <u>AUG 30 1967</u>						27. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

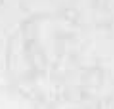
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
11680													
11692													
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>				23.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRINGHILL NURSING HOME</u>						d. STREET ADDRESS <u>R D 1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>C</u> Middle <u>Hastings</u> Last						4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1967</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/25/83</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ROT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>DEAN W. COLLINS</u>						14. MOTHER'S MAIDEN NAME <u>AMANDA COOPER</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Mr. William J. HASTINGS</u> <u>Ocean City, MD</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Parkinsonism</u> DUE TO (c) <u>Right Hip Fracture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>350X</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1-2 mos</u> <u>Yrs.</u> <u>May 1967</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> , 19 <u>67</u> , to <u>8/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/22</u> , 19 <u>67</u> , and that death occurred at <u>3:45 P.M.</u> from causes and on the date stated above													
22a. SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/29/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>						22d. ADDRESS <u>MEDICAL CENTER, SALISBURY</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>				23d. LOCATION (City or Town) (County) (State) <u>BERLIN WOR. MD.</u>					
24. FUNERAL DIRECTOR <u>Anna A. BURBAKE</u>						ADDRESS <u>BERLIN MD</u>		25a. REC'D BY REGISTRAR <u>SEP 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1912

DEPARTMENT OF CHEMISTRY



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
11681													
11693													
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 316 E. Vine Street						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 316 E. Vine Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MINNIE Middle VOSBURG Last HASTINGS						4. DATE OF DEATH Month August Day 26 Year 1967							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 4, 1892		9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William T. Scott						14. MOTHER'S MAIDEN NAME Mary Kelley							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-01-9542		17. INFORMANT Address Mr. Frank M. Hastings (Husband) 316 E. Vine Street, Salisbury, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cerebral arteriosclerosis & paralysis												INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from Jan 1961 to Aug 1967 that (I) (we) last saw the deceased alive on 26 Aug 1967 and that death occurred at 10:13 PM from the causes and on the date stated above.													
22a. SIGNATURE Dr. Robert T. Adkins M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED August 28, 1967					
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins						22d. ADDRESS Fruitland, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 30, 1967		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) Salisbury, Maryland		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY, SALISBURY, MARYLAND ADDRESS						25a. DATE OF REGISTRATION AUG 30 1967		25b. REGISTRATION NO. John A. Judge					

RESOLUTION OF DEATH

UNIVERSITY OF MARYLAND, COLLEGE PARK, MARYLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11682 Item 2 See birth cert. ams 11694									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Eden			23.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS R.D.#1, Meadow Bridge Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM PERRY HAVEY					4. DATE OF DEATH Month Day Year August 5 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Baby DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1967		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Perry Havey					14. MOTHER'S MAIDEN NAME Edna Frances Muir				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Perry Havey (Father) R.D.#1, Meadow Bridge Road, Salisbury, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 7561 DUE TO (b) Multiple Congenital Defects (Mongolism) DUE TO (c) and Imperforate Anus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/a					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from August 2, 1967 to August 5, 1967 , that (I) (we) last saw the deceased alive on August 5, 1967 , and that death occurred at 7:45 P.M. from causes and on the date stated above.									
22a. SIGNATURE William C. Morgan					22b. DATE SIGNED 8/5/67			22c. PHYSICIAN'S NAME (Type) Dr. William C. Morgan	
22d. ADDRESS Medical Center, Salisbury, Maryland					22e. REC'D BY REGISTRAR AUG 9 1967				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 8, 1967		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park			23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REG'D BY REGISTRAR Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

11683

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11685

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury Fruitland</u>		c. LENGTH OF STAY IN 1b <u>3 Mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forbes Nursing Home</u>				d. STREET ADDRESS <u>R. 9</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry Holland</u>				4. DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-1917</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Sussex Co. Dela.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joe Henry Holland</u>				14. MOTHER'S MAIDEN NAME <u>Annie Belle Martin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-12-5595</u>		17. INFORMANT <u>H. Davis Quillin, Jr.</u> Address <u>Berlin, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circumstances -</u> DUE TO <u>150X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4/14/67</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>4/14</u> , 19 <u>67</u> , to <u>8-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-29 1967</u> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>NEWS W. TODD</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/10/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>NEWS W. TODD</u>		22d. ADDRESS <u>MEDICAL CENTER SALISBURY</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-12-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Bethel</u>		23d. LOCATION (City or Town) (County) (State) <u>Berlin, Md.</u>			
24. FUNERAL DIRECTOR <u>Routa Bolley</u> Address <u>Jersey Rd. #122 Salisbury, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

1. Name of the plant: *...*
2. Locality: *...*
3. Date: *...*
4. Collector: *...*
5. Number: *...*
6. Description: *...*
7. Remarks: *...*
8. Distribution: *...*
9. Uses: *...*
10. Other: *...*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11684

11696

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Dykes Road	
3. NAME OF DECEASED (Type or print) ELLA First WISE Middle HUDSON Last		4. DATE OF DEATH Month August Day 16 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1894
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Avery Noek		14. MOTHER'S MAIDEN NAME Lurena Brittingham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) xx		16. SOCIAL SECURITY NO. 213-16-7878	
17. INFORMANT Naomi Lowe Dykes Road Salisbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-16, 1967 to 8-16, 1967 that (I) (we) last saw the deceased alive on 8-16, 1967 and that death occurred at 5:27 PM , from causes and on the date stated above.			
22a. SIGNATURE W. B. Elles, Jr.		22b. DATE SIGNED 8-16-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL, ETC. Evergreen		23b. DATE THEREOF 8/19/67	
23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION (City or Town) (County) (State) Berlin Worcester, Md.	
24. FUNERAL DIRECTOR Peter Whaley		25a. REC'D BY REGISTRAR DATE AUG 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Salisbury

Peninsula General Hospital

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SALISBURY
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
116897			
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 23-2		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 8 4th. Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Julius L. Hughes		4. DATE OF DEATH August 3 1967	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1893
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 3 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hughes		14. MOTHER'S MAIDEN NAME Jennie Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes War I		16. SOCIAL SECURITY NO. 143 12 8316	
17. INFORMANT Mrs. Sarah Hughes, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auto leukemia DUE TO (b) 2043 DUE TO (c) Auto leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH see above	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-2 , 19 67 , to 8-3 , 19 67 , that (I) (we) last saw the deceased alive on 8-3 , 19 67 , and that death occurred at 12:30 M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 8-4-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/5/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Wesley Cem.		23d. LOCATION (City or Town) (County) (State) White Haven, Md.	
24. FUNERAL DIRECTOR [Signature]		25a. REC'D BY REGISTRAR AUG 7 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

<div>11686</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>11698</div>											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital						d. STREET ADDRESS Box 9				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle FRANKLIN Last JOHNSON						4. DATE OF DEATH Month 8 Day 9 Year 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-1-36		9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) timber cutter				10b. KIND OF BUSINESS OR INDUSTRY Logging		11. BIRTHPLACE (State or foreign country) Crisfield, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Johnson						14. MOTHER'S MAIDEN NAME Vergie Howard					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Edna Sue Johnson, same as 2.abcd above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured thoracic aorta DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH sudden sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was loading logs on truck and log fell on him.							
20c. TIME OF INJURY Month, Day, Year Hour o.m. 10 xxx 8-9-67 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm		20f. (City or town) (County) (State) Princess Anne, Somerset, Md.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Earl L. Royer, M.D.						22. DATE SIGNED August 10, 1967					
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Aug.12,1967		23c. NAME OF CEMETERY OR CREMATORY Quinton Cemetery			23d. LOCATION (City or Town) (County) (State) Somerset County, Md.			
24. FUNERAL DIRECTOR Bradshaw Funeral Home, Crisfield, Md.						25a. REC'D BY REGISTRAR DATE AUG 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

UNITED STATES DEPARTMENT OF AGRICULTURE

Division

Office

Washington, D. C.

July 1907

Dear Sir:

Enclosed please find

for the Bureau

the report of the

Commissioner

X

X

X

X

Sincerely,
John D. Johnston

John D. Johnston, Secretary

Secretary, U. S. D. A.

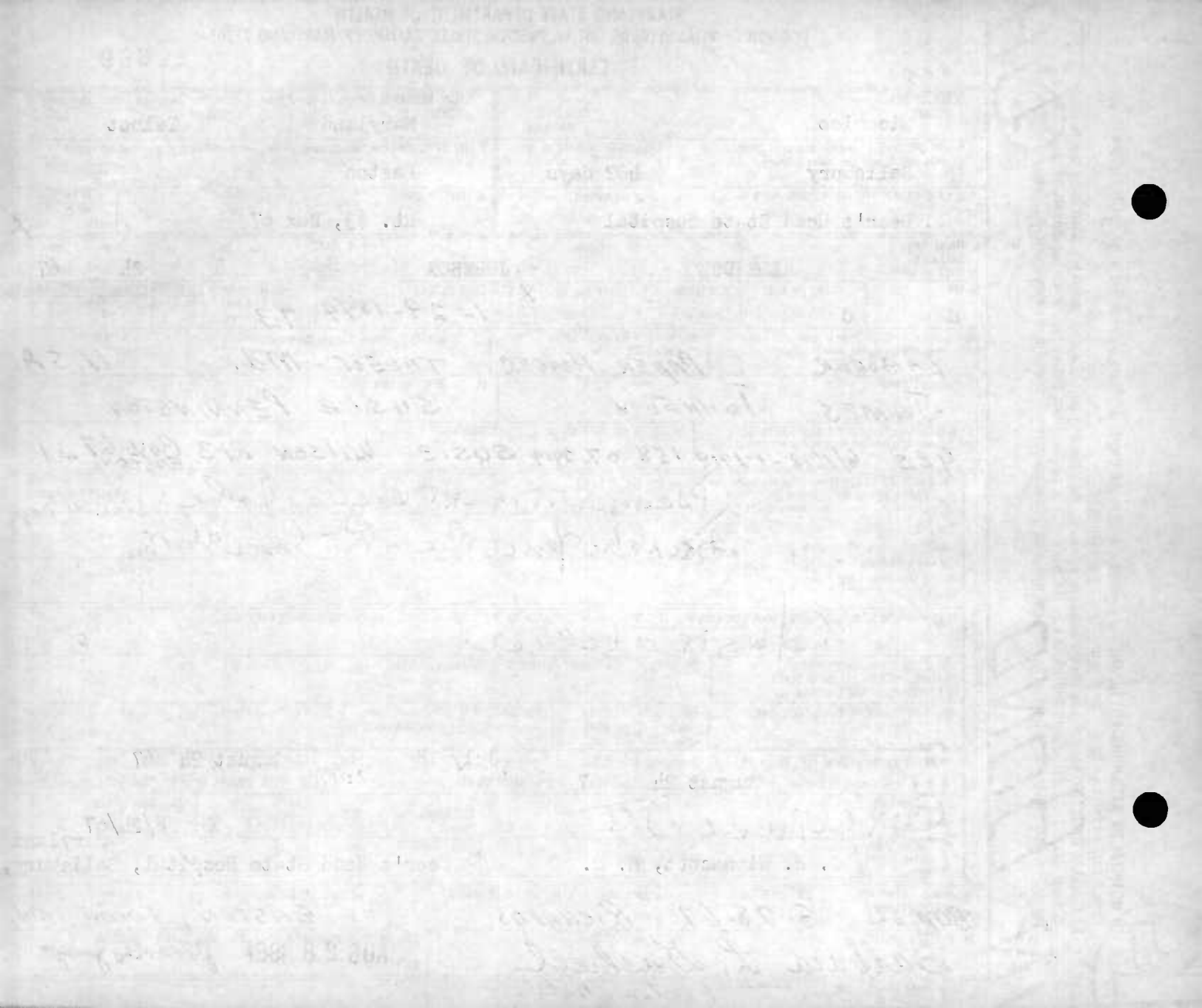
1907

CERTIFICATE OF DEATH

11699

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY in lb <u>402 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Rt. #3, Box 67</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALDRIDGE</u> <u>JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>8</u> <u>24</u> <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1-29-1894</u>		9. AGE (In years last birthday) yrs. <u>73</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAPER HANGER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>SUSIE PENNINGTON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>6/1918-1-1919</u>		16. SOCIAL SECURITY NO. <u>158-07-2919</u>		17. INFORMANT Address <u>SUSIE Wilson Rt 3, Box 67 md. Easton</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Rt. lower lobe -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchopneumonia - Rt. lower lobe -</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>10-14 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gas embolism</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour "o.m." p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 18</u> , 1966, to <u>August 24</u> , 1967, that (I) (we) last saw the deceased alive on <u>August 24</u> , 1967, and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. H. Winnacott, M. D.</u>				22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-28-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RICHARDS</u>		23d. LOCATION (City or town) (County) (State) <u>EASTON, TALBOT, Md.</u>	
24. FUNERAL DIRECTOR <u>Barbara L. Dashiell</u>				ADDRESS <u>426 Dove St. Easton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 28 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R.D.#2</u>	
3. NAME OF DECEASED (Type or print) First <u>LEVIN</u> Middle <u>WASHINGTON</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 27, 1884</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William T. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Hopkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-20-5827-A</u>	
17. INFORMANT <u>Mr. Ralph William Jones (Nephew)</u> <u>R.D.#2, Eden, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>A.S.C.V.D. rheumatoid arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-13</u> , 19 <u>67</u> , to <u>8-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-15</u> , 19 <u>67</u> , and that death occurred at <u>5:00</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Adkins</u>		22b. DATE SIGNED <u>15 Aug 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert T. Adkins</u>		22d. ADDRESS <u>Fruitland, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 17, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

11689

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11701

FOR STATE HEALTH DEPT.

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>14 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula Inn, Hospital</u>		d. STREET ADDRESS <u>113 East St</u>	
3. NAME OF DECEASED (Type or print) <u>Ethan A. Kenny</u>		4. DATE OF DEATH <u>August 20,</u> 19 <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1885</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paint</u>	
11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Kenny</u>		14. MOTHER'S MAIDEN NAME <u>Mother Ellis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>221-09-1204</u>	
17. INFORMANT <u>Mollie Kenny</u>		Address <u>Delmar Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Fracture left femur</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell @ home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>8/6/67</u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Delmar</u> (County) <u>Wicomico</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles Judge</u> M.D.		22. DATE SIGNED <u>8/25/67</u>	
EXAMINER'S NAME (Type) <u>W.H. I. P. + Instory</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Alphonsus Cem</u>	23d. LOCATION (City or Town) <u>Delmar</u> (County) <u>Wicomico</u> (State) <u>Del.</u>
24. FUNERAL DIRECTOR <u>William Marshall</u>		25. REC'D BY REGISTRAR <u>Delmar Del</u>	
ADDRESS <u>Delmar Del</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 28 1967</u>			

CERTIFICATE OF DEATH

11702

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Spring Hill Road	
3. NAME OF DECEASED (Type or print) EDWARD LESH		4. DATE OF DEATH August 1, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1889
		9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mfg. Representative-Road Bldg. Material-Frenchtown, N.J.		11. BIRTHPLACE (County & State, or foreign country) USA	
13. FATHER'S NAME John Lantz		14. MOTHER'S MAIDEN NAME Lillian Delrimple	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes War I		16. SOCIAL SECURITY NO. 217-54-5738	
		17. INFORMANT Mrs. Mary P. Morris Lantz (Wife) Address Spring Hill Road, Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema. DUE TO (b) Respiratory Tract Infection. DUE TO (c) Coronary Artery Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 6 hours 18 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Artery Heart Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from March, 1966 to 8/1/67 , that (I) (we) last saw the deceased alive on 8/1/67 , and that death occurred at M , from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE Dr. O. J. Burton		22b. DATE SIGNED August 1, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. O. J. Burton		22d. ADDRESS Medical Center, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF August 3, 1967	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALIBBURY, MARYLAND		25. REC'D BY REGISTRAR AUG 4 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>		<p>7. Time of death</p>		<p>8. Place of death</p>	
<p>9. Cause of death</p>		<p>10. Manner of death</p>		<p>11. Signature of physician</p>		<p>12. Signature of registrar</p>	
<p>13. Signature of informant</p>		<p>14. Signature of witness</p>		<p>15. Signature of registrar</p>		<p>16. Signature of registrar</p>	
<p>17. Signature of registrar</p>		<p>18. Signature of registrar</p>		<p>19. Signature of registrar</p>		<p>20. Signature of registrar</p>	
<p>21. Signature of registrar</p>		<p>22. Signature of registrar</p>		<p>23. Signature of registrar</p>		<p>24. Signature of registrar</p>	
<p>25. Signature of registrar</p>		<p>26. Signature of registrar</p>		<p>27. Signature of registrar</p>		<p>28. Signature of registrar</p>	
<p>29. Signature of registrar</p>		<p>30. Signature of registrar</p>		<p>31. Signature of registrar</p>		<p>32. Signature of registrar</p>	
<p>33. Signature of registrar</p>		<p>34. Signature of registrar</p>		<p>35. Signature of registrar</p>		<p>36. Signature of registrar</p>	
<p>37. Signature of registrar</p>		<p>38. Signature of registrar</p>		<p>39. Signature of registrar</p>		<p>40. Signature of registrar</p>	
<p>41. Signature of registrar</p>		<p>42. Signature of registrar</p>		<p>43. Signature of registrar</p>		<p>44. Signature of registrar</p>	
<p>45. Signature of registrar</p>		<p>46. Signature of registrar</p>		<p>47. Signature of registrar</p>		<p>48. Signature of registrar</p>	
<p>49. Signature of registrar</p>		<p>50. Signature of registrar</p>		<p>51. Signature of registrar</p>		<p>52. Signature of registrar</p>	
<p>53. Signature of registrar</p>		<p>54. Signature of registrar</p>		<p>55. Signature of registrar</p>		<p>56. Signature of registrar</p>	
<p>57. Signature of registrar</p>		<p>58. Signature of registrar</p>		<p>59. Signature of registrar</p>		<p>60. Signature of registrar</p>	
<p>61. Signature of registrar</p>		<p>62. Signature of registrar</p>		<p>63. Signature of registrar</p>		<p>64. Signature of registrar</p>	
<p>65. Signature of registrar</p>		<p>66. Signature of registrar</p>		<p>67. Signature of registrar</p>		<p>68. Signature of registrar</p>	
<p>69. Signature of registrar</p>		<p>70. Signature of registrar</p>		<p>71. Signature of registrar</p>		<p>72. Signature of registrar</p>	
<p>73. Signature of registrar</p>		<p>74. Signature of registrar</p>		<p>75. Signature of registrar</p>		<p>76. Signature of registrar</p>	
<p>77. Signature of registrar</p>		<p>78. Signature of registrar</p>		<p>79. Signature of registrar</p>		<p>80. Signature of registrar</p>	
<p>81. Signature of registrar</p>		<p>82. Signature of registrar</p>		<p>83. Signature of registrar</p>		<p>84. Signature of registrar</p>	
<p>85. Signature of registrar</p>		<p>86. Signature of registrar</p>		<p>87. Signature of registrar</p>		<p>88. Signature of registrar</p>	
<p>89. Signature of registrar</p>		<p>90. Signature of registrar</p>		<p>91. Signature of registrar</p>		<p>92. Signature of registrar</p>	
<p>93. Signature of registrar</p>		<p>94. Signature of registrar</p>		<p>95. Signature of registrar</p>		<p>96. Signature of registrar</p>	
<p>97. Signature of registrar</p>		<p>98. Signature of registrar</p>		<p>99. Signature of registrar</p>		<p>100. Signature of registrar</p>	

1

101. Signature of registrar

11691

CERTIFICATE OF DEATH

11703

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 373 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) ETHEL GRACE LAYTON		4. DATE OF DEATH Month 8 Day 3 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1894
9. AGE (In years lost birthday) yrs. 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) R.D., Willards, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William G. Dennis		14. MOTHER'S MAIDEN NAME Nancy Elizabeth Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-14-8783B	
17. INFORMANT Mr. Walter Lee Layton (Husband) Willards, Maryland		18. ADDRESS Willards, Maryland	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral hemorrhage DUE TO (b) Subarachnoid hemorrhage (May 1966) DUE TO (c) 15 months			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 26, 1966 , to August 3, 1967 , that (I) (we) last saw the deceased alive on August 3, 1967 , and that death occurred at 4:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE A. C. Mitchell		22b. DATE SIGNED 8/4/67 Md.	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF August 6, 1967	23c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery	23d. LOCATION (City or Town) (County) (State) Pittsville, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE AUG 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

W. M. L. L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

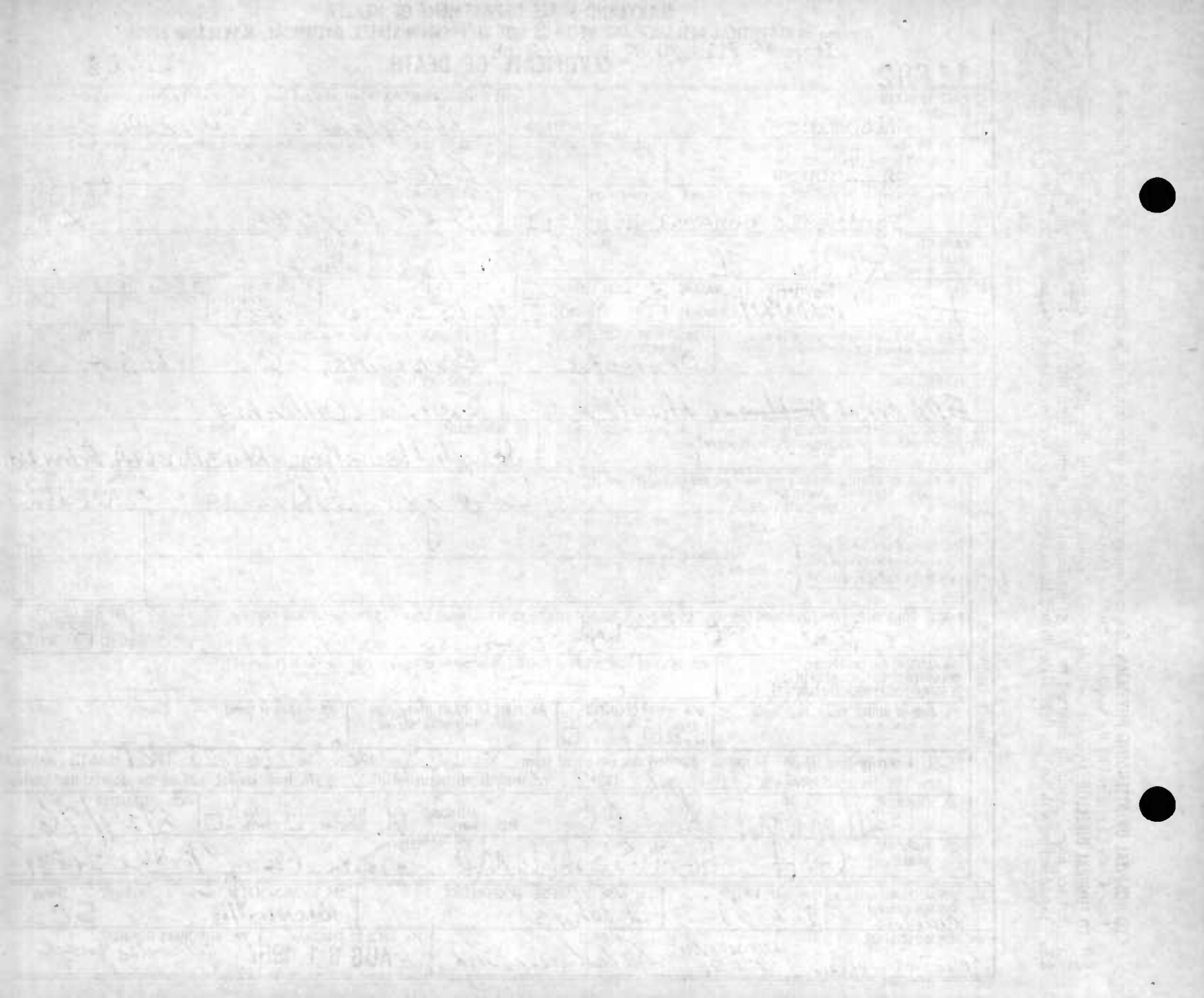
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #6 Film #G392 8/18/67 ph

CERTIFICATE OF DEATH

11692

11704

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>Eden</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Rt #3 Box 64A</u>	
3. NAME OF DECEASED (Type or print) <u>Ruby I. LLEWELYN</u>		4. DATE OF DEATH <u>August 28 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Nonwhite</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>43</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bornwills, S.C.</u>	
13. FATHER'S NAME <u>Ephraim William Hunter</u>		14. MOTHER'S MAIDEN NAME <u>Grace Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joseph Llewelyn - Rt #3 Box 64A Eden Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>201X</u> DUE TO <u>Hodgkins Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>9 months</u> (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pleuritis - Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 8, 1967</u> to <u>Aug 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 28, 1967</u> , and that death occurred at <u>7:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. Herbert Sembly</u>		22b. DATE SIGNED <u>8/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly MD</u>		22d. ADDRESS <u>Salisbury Md. 21881</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-3-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		23d. LOCATION (City or Town) (County) (State) <u>Bornwills S.C.</u>	
24. FUNERAL DIRECTOR <u>Louise B. Jolley</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Rt #2 Salisbury, Md.</u>		DATE <u>AUG 31 1967</u>	



11693

CERTIFICATE OF DEATH

11705

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>19.2</u>	
3. NAME OF DECEASED (Type or print) <u>Ethel</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1889</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Daniel Miles</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Keene</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robt. C. Biggy Long, Westover, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 1992 DUE TO <u>Large Metastatic Carcinoma of Loin</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Primary Unknown</u> (b) <u>Primary Unknown</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8:3</u> , 19 <u>67</u> to <u>8:24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8:24</u> , 19 <u>67</u> , and that death occurred at <u>6:29</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>H. H. Brielle</u>		22b. DATE SIGNED <u>8-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. H. Brielle</u>		22d. ADDRESS <u>Medical Center Salisbury Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>8/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Manokin Presbyterian</u>	23d. LOCATION (City or Town) (County) (State) <u>Princess Anne; Somerset Co Md</u>
24. FUNERAL DIRECTOR <u>James L. Linneman</u>		25. REC'D BY REGISTRAR <u>Princess Anne, Md.</u>	
25a. DATE <u>AUG 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1185

CERTIFICATE OF DEATH

Prisoner Name

Prisoner No.

Prisoner Name

Prisoner Name

Prisoner Name

Prisoner Name

Prisoner Name

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Prisoner Name

Prisoner Name

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11694

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11706

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 50 & Hebron Road</u>	
d. STREET ADDRESS <u>3602 Crossland Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BRIAN</u> Middle <u>LOUIS</u> Last <u>MARTIN</u>		4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-45</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months <u>22</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herbert E. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Ruth C. Conrad</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217462032</u>	
17. INFORMANT <u>Mr. Herbert E. Martin- Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 8164 DUE TO (b) <u>Third degree burns</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto struck from behind by another vehicle.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> p.m. <u>8-25-67</u> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 50 & Hebron Rd.</u>		20f. (City or town) (County) (State) <u>Wicomico, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		22. DATE SIGNED <u>August 26, 1967</u>	
EXAMINER'S NAME (Type) <u>409 Camden Ave., Salisbury, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/29/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem. Baltimore Co. Md.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard Ruck, Inc., Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 28 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

I have been thinking of you
and the way you are
and the way you are

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11695

11707

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in 1b 63 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marydel <i>05-2</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS RD #1, Box 94		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IOLA LOCKLEAR MAYULIANOS First Middle Last				4. DATE OF DEATH Month 8 Day 23 Year 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1932		9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Genevieve Locklear		14. MOTHER'S MAIDEN NAME Monty Jane Locklear		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Nicholas Mayulianos		Address Marydel, Md.		INTERVAL BETWEEN ONSET AND DEATH 6 months	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 6000 IMMEDIATE CAUSE (a) Uremia DUE TO (b) Chronic pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 21 , 19 67 , to August 23 , 19 67 , that (I) (we) lost the deceased alive on August 23 , 19 67 , and that death occurred at 2:00 A.M. , from causes on and on the date stated above.							
22a. SIGNATURE L. V. Maldve				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/23/67	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				22d. ADDRESS Maryland Deer's Head State Hospital, Salisbury,			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/28/67		23c. NAME OF CEMETERY OR CREMATORY Rosewood Cem.		23d. LOCATION (City or Town) (County) (State) Rosewood Robinson N. Car	
24. FUNERAL DIRECTOR William S. Mord				25a. REC'D BY REGISTRAR Admar, Del.		25b. REGISTRAR'S SIGNATURE James Judge	

MEDICAL CERTIFICATION

STATEMENT OF WORK

1985

PROJECT

LOCATION

DATE

BY

FOR

PROJECT DESCRIPTION

PROJECT OBJECTIVES

DATE

PROJECT LOCATION

DATE

The project is to develop a land management plan for the [redacted] area. The plan will include a description of the area, a list of resources, and a plan for managing the resources. The plan will be developed in accordance with the [redacted] Act and the [redacted] Regulations. The plan will be developed in consultation with the [redacted] and the [redacted]. The plan will be developed in accordance with the [redacted] Act and the [redacted] Regulations. The plan will be developed in consultation with the [redacted] and the [redacted].

DATE

DATE

PROJECT DESCRIPTION

PROJECT LOCATION

DATE

DATE

DATE

DATE

PROJECT DESCRIPTION

DATE

The project is to develop a land management plan for the [redacted] area. The plan will include a description of the area, a list of resources, and a plan for managing the resources. The plan will be developed in accordance with the [redacted] Act and the [redacted] Regulations. The plan will be developed in consultation with the [redacted] and the [redacted]. The plan will be developed in accordance with the [redacted] Act and the [redacted] Regulations. The plan will be developed in consultation with the [redacted] and the [redacted].

PROJECT OBJECTIVES

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11696

CERTIFICATE OF DEATH

11708

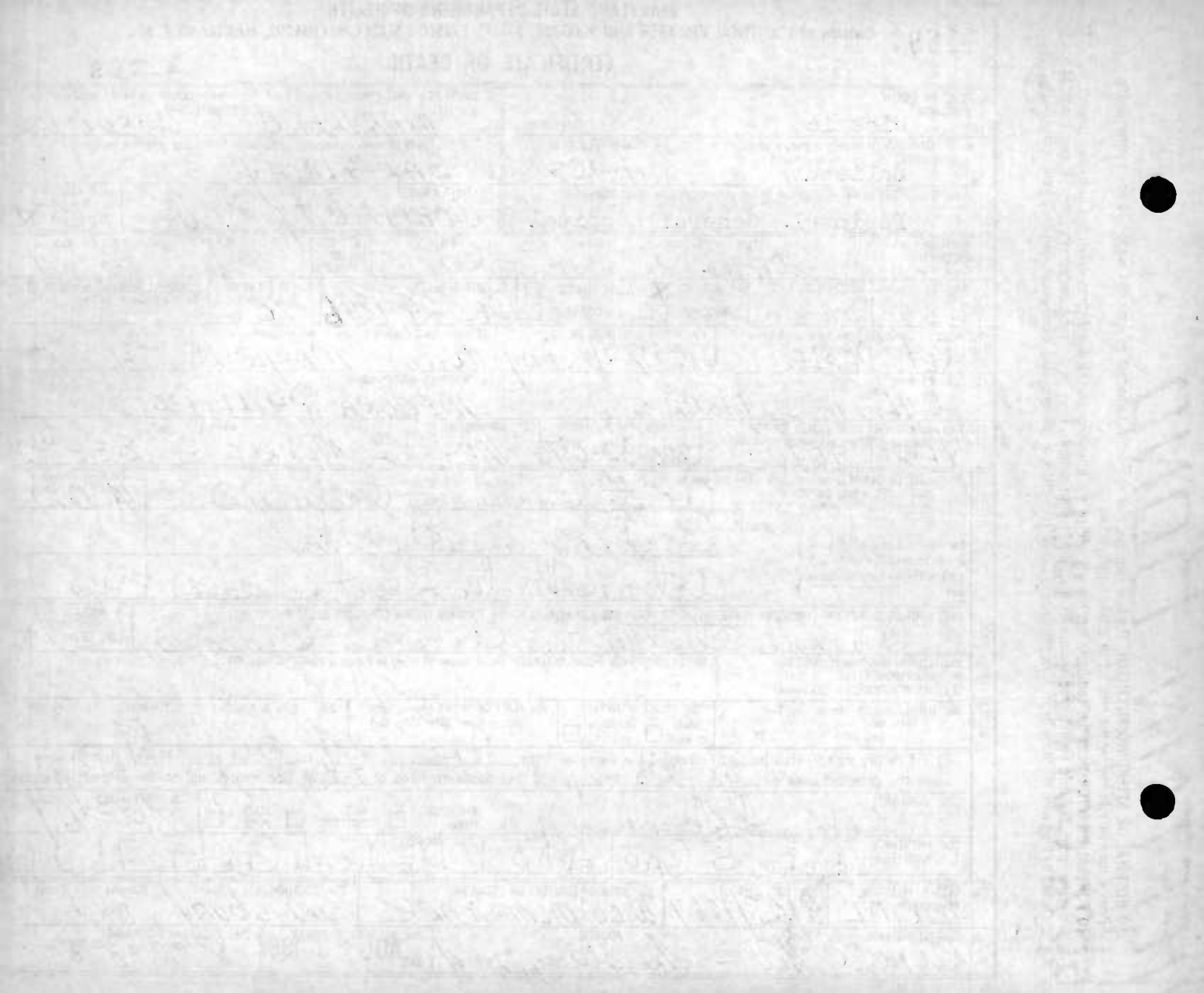
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS Bayside & Caroline Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DAVID MOBERG				4. DATE OF DEATH Month Day Year 8 2 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1894		9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE + GARDNER		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 198-05-1545		17. INFORMANT Address Wm. J.J. Manning, Rock Hall, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the esophagus (middle third) 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19, 1967 , to August 2, 1967 , that (I) (we) last saw the deceased alive on August 2, 1967 , and that death occurred at 4:05 P.M. from causes and on the date stated above.							
22a. SIGNATURE Chas H Winnacott				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/3/67	
22c. PHYSICIAN'S NAME (Type) Chas. H. Winnacott, M. D.				22d. ADDRESS Maryland Deer's Head State Hospital, Salisbury,			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Aug. 5, 1967		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION (City or Town) (County) (State) Rock Hall, Kent, Md.	
24. FUNERAL DIRECTOR Edgar L. Lane				25a. REC'D BY REGISTRAR Aug 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

11697 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
11709													
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN lb <u>4 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>OCEAN CITY BLVD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rutter</u> Middle <u>Linwood</u> Last <u>MORRIS</u>						4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1967</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 29, 1896</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>RET. DEALER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FR. MACHINERY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wico. - MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>CALVIN D. MORRIS</u>						14. MOTHER'S MAIDEN NAME <u>MEDORA PHILLIPS</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>220-32-0872</u>		17. INFORMANT <u>MRS. N.L. MORRIS</u> Address <u>SEE #2</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Acute Coronary Occlusion</u> DUE TO <u>Cardiogenic Shock</u> (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Obstructive Airway Disease</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>									
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>					
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1957</u> to <u>Aug. 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug. 23, 1967</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.													
22a. SIGNATURE <u>Rufus S. Gardner</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/23/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>RUFUS S. GARNER</u>						22d. ADDRESS <u>MEDICAL CENTER SALISBURY</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/25/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WICO. MEM. PARK</u>				23d. LOCATION (City or Town) (County) (State) <u>SALISBURY, MD</u>					
24. FUNERAL DIRECTOR <u>George Neil - Salisbury, Md.</u>						ADDRESS <u> </u>		25a. REC'D BY REGISTRAR DATE <u>AUG 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
11698					CERTIFICATE OF DEATH					11710				
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 11 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Upshur William Morris					4. DATE OF DEATH Month Day Year August 5 19 67									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 16, 1883		9. AGE (In years last birthday) yrs. 84		IF UNDER 1 Year Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR			10b. KIND OF BUSINESS OR INDUSTRY BUILDING			11. BIRTHPLACE (County & State, or foreign country) WICOMICO MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME THOMAS C. MORRIS					14. MOTHER'S MAIDEN NAME ELIZABETH WILLIAMS									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records - Salisbury, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) Carcinoma of head of pancreas DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH Jan 67				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 7/25/67 , 19 67 , to Aug. 5, 19 67 , that (I) (we) last saw the deceased alive on Aug. 5, 19 67 , and that death occurred at 9:15 M. from causes and on the date stated above.														
22a. SIGNATURE Andrew Mitchell					22b. ADDRESS Deer's Head State Hosp., Box 2018, Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 8/8/1967		23c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY			23d. LOCATION (City or Town) (County) (State) SALISBURY, MARYLAND						
24. FUNERAL DIRECTOR George C. Neil Salisbury, Md.					25a. REC'D BY REGISTRAR DATE AUG 8 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge							

Commissioner of Land & Agriculture

8/2/67 x

W. H. H. H.

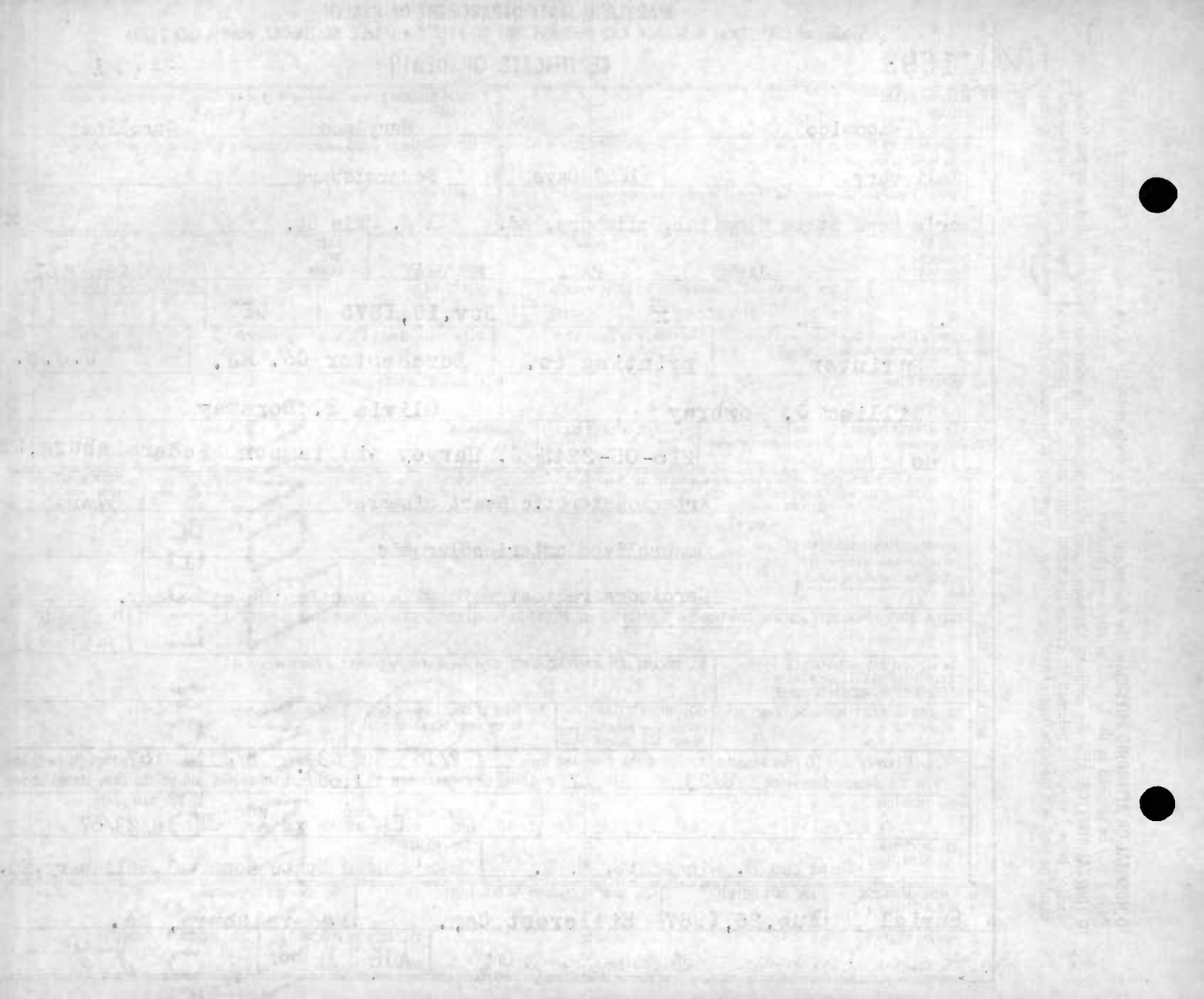
CERTIFICATE OF DEATH

11711

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg	
c. LENGTH OF STAY IN lb 1647 Days		d. STREET ADDRESS 221 N. Main St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle PAUL Last MOWBRAY		4. DATE OF DEATH Month 8 Day 23 Year 19 67	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1875
9. AGE (In years last birthday) yrs. 91		10. IF UNDER 1 YEAR Months 23 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) printer		10b. KIND OF BUSINESS OR INDUSTRY printing co.	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Mowbray		14. MOTHER'S MAIDEN NAME Olivia P. Conaway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-05-3243	
17. INFORMANT J. Harvey Williamson		Address Federalsburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized arteriosclerosis DUE TO (c) Carcinoma rectosigmoid with functioning colostomy.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4200			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/18 , 19 63 , to 8/23 , 19 67 , that (I) (we) last saw the deceased alive on 8/23 , 19 67 , and that death occurred at 11:08 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Charles H. Winnacott		22b. DATE SIGNED 8/23/67	
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF Aug. 26, 1967	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.	23d. LOCATION (City or Town) (County) (State) Federalsburg, Md.
24. FUNERAL DIRECTOR Harvey Williamson - Federalsburg, Md.		25a. REC'D BY REGISTRAR AUG 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

11712

1700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Melissa		4. DATE OF DEATH August 19 1967	
5. SEX Female	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 1/1/67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sylvester Williams		14. MOTHER'S MAIDEN NAME Annie Oliver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Annie Oliver		Address Pocomoke, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Diffuse Bronchopneumonia (intercurrent) DUE TO (b) approx 4 days DUE TO (c) approx 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastroenteritis (cause for initial hospital admission)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/24 , 19 67 , to 8/1 , 19 67 , that (II) (we) last saw the deceased alive on 8/1 , 19 67 , and that death occurred at 11 A.M. from causes and on the date stated above.			
22a. SIGNATURE Alfred C. Kells M.D.		22b. DATE SIGNED 8/2/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Medical Center Salisbury Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/6/67	23c. NAME OF CEMETERY OR CREMATORY Green Arces Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md.
24. FUNERAL DIRECTOR Clifton F. Stewart		25a. REC'D BY REGISTRAR DATE AUG 8 1967	
ADDRESS Salisbury - Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Parsonsborg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS P.O. Box 106	
13. NAME OF DECEASED First HOWARD Middle W. Last PARKER		4. DATE OF DEATH Month 8 Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 69 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Parker		14. MOTHER'S MAIDEN NAME Annie E. Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-12-6553	
17. INFORMANT Mazzie West		Address Main St. Salisbury Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED August 31, 1967	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/2/1967	23c. NAME OF CEMETERY OR CREMATORY Glass Hill	23d. LOCATION (City or Town) (County) (State) Parsonsborg Md.
24. FUNERAL DIRECTOR Clinton Stewart		25a. REC'D BY REGISTRAR DATE SEP 6 1967	
ADDRESS Clinton Stewart Funeral Home, Salisbury, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

John L. Hager

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11702

11714

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN TB MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fruitland d. STREET ADDRESS Carey Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELWOOD FRANKLIN PARSONS				4. DATE OF DEATH Month Day Year August 26 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 19, 1906	
9. AGE (in years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Attendant - Service Sta.				10b. KIND OF BUSINESS OR INDUSTRY Wicomico County, Maryland		11. BIRTHPLACE (County & State, or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Daniel Parsons				14. MOTHER'S MAIDEN NAME Minnie Lecates			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 214-10-7874				17. INFORMANT Address Mrs. Edith White Parsons (Wife) Carey Ave., Fruitland, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Abdominal Aneurysm 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) N/A							INTERVAL BETWEEN ONSET AND DEATH 14 hrs. 5 yrs
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-25-67 to 8-26-67 that (I) (we) last saw the deceased alive on 8-26-67 and that death occurred at 12:45 AM from the causes and on the date stated above.							
22a. SIGNATURE Dr. E. Kent Carney M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED August 28/1967	
22c. PHYSICIAN'S NAME (Type) Dr. E. Kent Carney				22d. ADDRESS Medical Center, Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 29, 1967		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town or county) (State) Fruitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY, SALISBURY, MARYLAND ADDRESS				25a. REC'D BY REGISTRAR DAUG 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, VIRGINIA

1912

1912

NAME OF DECEASED
AGE
SEX
RACE
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH

DATE OF BIRTH
PLACE OF BIRTH
MARRIAGE
OCCUPATION
EDUCATION

PREVIOUS ILLNESS
MEDICAL ATTENDANCE
HISTORY OF DEATH

SIGNATURE OF PHYSICIAN
SIGNATURE OF WITNESSES
DATE OF SIGNATURE

NAME OF DECEASED
AGE
SEX
RACE
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH

DATE OF BIRTH
PLACE OF BIRTH
MARRIAGE
OCCUPATION
EDUCATION

PREVIOUS ILLNESS
MEDICAL ATTENDANCE
HISTORY OF DEATH

SIGNATURE OF PHYSICIAN
SIGNATURE OF WITNESSES
DATE OF SIGNATURE

NAME OF DECEASED
AGE
SEX
RACE
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11703

CERTIFICATE OF DEATH

11715

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> 19-2	
c. LENGTH OF STAY IN 1b <u>12 days</u>		d. STREET ADDRESS <u>Route 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Maylon</u> Last <u>Pinkett</u>		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1892</u> 73 yrs.
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Pinkett</u>		14. MOTHER'S MAIDEN NAME <u>Annie Anderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-2110</u>	
17. INFORMANT <u>Veda Pinkett</u>		Address <u>Princess Anne, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate - Metastatic</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 8, 1967</u> , to <u>August 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 20, 1967</u> , and that death occurred at <u>6:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>A. C. Mitchell</u>		22b. DATE SIGNED <u>8/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M. D.</u>		22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Mt. Vernon Md.</u>
24. FUNERAL DIRECTOR <u>Samuel Lange</u>		25a. REC'D BY REGISTRAR <u>Charles J. ...</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>		DATE <u>AUG 25 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11704						11716					
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Powellville c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D., Pittsville						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Powellville d. STREET ADDRESS R.D., Pittsville e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR GRAY POWELL						4. DATE OF DEATH Month Day Year August 16 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1891		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elijah Powell						14. MOTHER'S MAIDEN NAME Mary Martha (Polly) Adkins					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-09-1562		17. INFORMANT Address Mr. Gorman H. Powell (Son) R.D., Pittsville, Powellville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4200 DUE TO (b) Arteriosclerotic Heart Disease 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Generalized arteriosclerosis 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) N/A							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Sept 1963 to 8/16, 1967 , that (I) (we) last saw the deceased alive on 8/16, 1967 , and that death occurred at 5:45 AM from the causes and on the date stated above.											
22a. SIGNATURE Dr. Frank E. Gantz M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED August 18/1967			
22c. PHYSICIAN'S NAME (Type) Dr. Frank E. Gantz						22d. ADDRESS 5 Bay Street, Berlin, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 18, 1967		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery				23d. LOCATION (City, town or county) (State) Powellville, Maryland			
24 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. REC'D BY REGISTRAR AUG 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

STATEMENT OF CLAIM

STATEMENT OF CLAIM

STATEMENT OF CLAIM

STATEMENT OF CLAIM

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11705

CERTIFICATE OF DEATH

11717

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Snow Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>417 Dighton Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>MARTIN</u> Middle <u>H</u> Last <u>PURNELL</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7, 1928</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Martin Dale</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Purnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Shirley Tindley</u>		Address <u>Snow Hill, Md.</u> <u>417 Dighton Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ess Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ess Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at <u>12:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>David J. Gilmore</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baptist</u>	23d. LOCATION (City or Town) (County) (State) <u>Snow Hill</u> <u>Worce Md.</u>
24. FUNERAL DIRECTOR <u>Loretta B. Jolley</u>		25a. REC'D BY REGISTRAR <u>Jersey Rd. Rt 42</u> <u>Salisbury, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 21 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

11706

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11718

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS ST LOUIS AVE	
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last Guillen		4. DATE OF DEATH Month August Day 5 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 28, 1904
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 5 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
11. BIRTHPLACE (County & State, or foreign country) STANLEYVILLE MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN J. W. M. GUILLÉN		14. MOTHER'S MAIDEN NAME LULA BLOXOM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-7287	
17. INFORMANT MRS. J. W. M. GUILLÉN		Address Ocean City MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5271 IMMEDIATE CAUSE (a) Pulmonary embolism & congestion DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-25 , 19 67 , to 8-5 , 19 67 , that (I) (we) last saw the deceased alive on 8-4 , 19 67 , and that death occurred at 1230 M, from causes on and on the date stated above.			
22a. SIGNATURE William W. Tuller		22b. DATE SIGNED 8-5-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/7/67	23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL	23d. LOCATION (City or Town) (County) (State) BERLIN W. CO. MD
24. FUNERAL DIRECTOR Anna A. Burbage		25a. REC'D BY REGISTRAR DATE AUG 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11707		11719	
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1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) residence of Samuel Hull		d. STREET ADDRESS Log Cabin Rd.	
3. NAME OF DECEASED (Type or print) CLIFTON COLUMBUS REID		4. DATE OF DEATH Month 8 Day 5 Year 67	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-35
9. AGE (In years lost birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Reid		14. MOTHER'S MAIDEN NAME Foxn Bailey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT John Reid, Tyaskin, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of abdomen DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 981X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot at close range with shotgun by assailant.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2 8-5-67 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Tyaskin, Wicomico, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> Earl L. Royer			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED August 8, 1967	
EXAMINER'S NAME (Type) 109 Camden Ave., Salisbury, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/8/67	23c. NAME OF CEMETERY OR CREMATORY Trinity Cem.	23d. LOCATION (City or Town) (County) (State) Boston, Va.
24. FUNERAL DIRECTOR Messick Funeral Home, Bivalve, Md.		25a. REC'D BY REGISTRAR DATE AUG 10 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

25th July
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

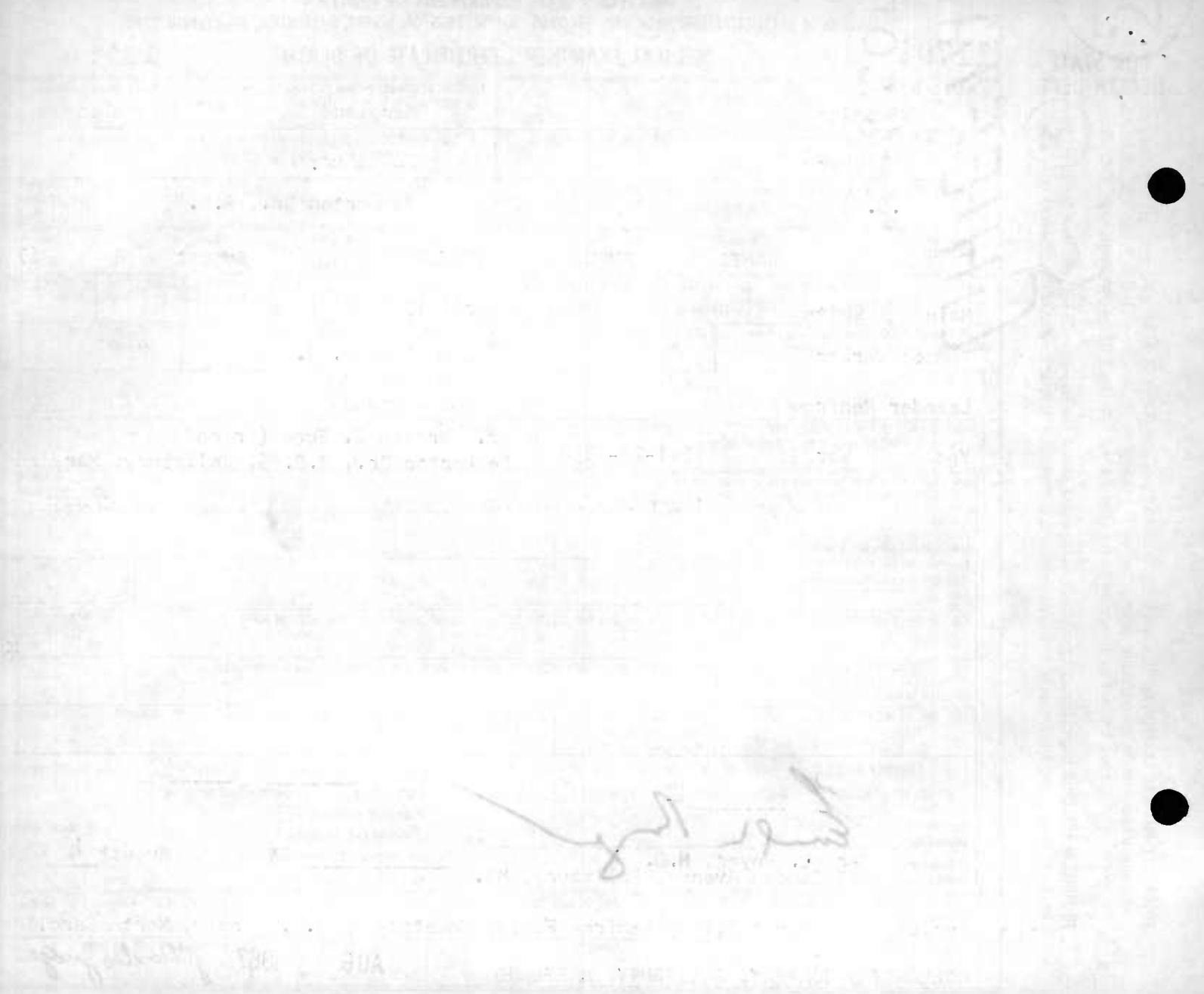
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11708

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11720

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.#5				d. STREET ADDRESS Pemberton Dr., R.D.#5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle RUFUS Last RENFROW				4. DATE OF DEATH Month August Day 3 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 17, 1914		9. AGE (In years last birthday) yrs. 53	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timber Worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Johnston, N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leander Renfrow				14. MOTHER'S MAIDEN NAME Nodie Deans			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War II		16. SOCIAL SECURITY NO. 241-20-2338		17. INFORMANT Mr. Parrish S. Eure (Friend) Pemberton Dr., R.D.#5, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3221 IMMEDIATE CAUSE (a) Chronic alcoholism DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED August 4 / 1967	
EXAMINER'S NAME (Type) 409 Camden Avenue, Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 5, 1967		23c. NAME OF CEMETERY OR CREMATORY Renfrow Family Cemetery		23d. LOCATION (City or Town) (County) (State) R.D., Kenly, North Carolina	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR AUG 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



9-6-67 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11709

CERTIFICATE OF DEATH

11721

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Salem	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 67.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. STREET ADDRESS 9 Johnstone Street	
3. NAME OF DECEASED (Type or print) First Merrill Middle H. Last Robinson		4. DATE OF DEATH Month August Day 27 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-23
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Const. Eng.		10b. KIND OF BUSINESS OR INDUSTRY Chemical	
11. BIRTHPLACE (County & State, or foreign country) New Hope, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James C. Robinson		14. MOTHER'S MAIDEN NAME Elsie T. Robinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Navy		16. SOCIAL SECURITY NO. 221-12-5243	
17. INFORMANT Frances B. Robinson		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Food Poisoning DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of Pancreas metastatic, coronary sclerosis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt found dead in bed approx 5:15 AM	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 15 Aug , 19 67 to 27 Aug , 19 67 that (I) (we) last saw the deceased alive on 26 Aug , 19 67 , and that death occurred at 5:43 AM , from causes and on the date stated above.			
22a. SIGNATURE Robert Adkins		22b. DATE SIGNED 27 Aug 67	
22c. PHYSICIAN'S NAME (Type) Robert Adkins		22d. ADDRESS Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-29-67	23c. NAME OF CEMETERY OR CREMATORY At Sea, 10 miles out off	23d. LOCATION (City or Town) (County) (State) Ocean City, Maryland
24. FUNERAL DIRECTOR Thomas F. Wallace		25. REC'D BY REGISTRAR AUG 31 1967	
25b. REGISTRAR'S SIGNATURE James J. J...			

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CERTIFICATE OF DEATH

11722

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>GeorgeTown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>309 CEDAR ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>ROGERS</u> Last <u>ROGERS</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 29, 1892</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE W. PALMER</u>		14. MOTHER'S MAIDEN NAME <u>MARY ALICE BEIDMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>221-32-2273</u>	
17. INFORMANT <u>1 ZETTA R. Sipple</u>		Address <u>Georgetown DELAWARE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure - Congestive</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes</u> <u>Arteriosclerotic Heart Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-18-1967</u> to <u>8-19-1967</u> , that (I) (we) last saw the deceased alive on <u>8-18-1967</u> , and that death occurred at <u>7:50</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>James L. Clifford</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JAMES L. CLIFFORD</u>		22d. ADDRESS <u>Medical Center Salisbury Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/22/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS Church</u>		23d. LOCATION (City or Town) (County) (State) <u>Georgetown DEL.</u>	
24. FUNERAL DIRECTOR <u>William J. Esham Jr.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 22 1967</u>	

CERTIFICATE OF DEATH

11723

11711

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 308 Pine St	
3. NAME OF DECEASED (Type or print) EUGENE GROVER ROSS		4. DATE OF DEATH Month AUG Day 1 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman		10b. KIND OF BUSINESS OR INDUSTRY Frm. Railroad	9. AGE (In years last birthday) yrs. 88
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME unknown		14. MOTHER'S MARRIED NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Edith Ross		Address Delmar Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO (b) arteriosclerotic heart dis. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 4 hours Est. 8 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/4 , 19 67 , to death , 19 67 , that (I) (we) last saw the deceased alive on 8/1 , 19 67 , and that death occurred at 12:30 M, from causes and on the date stated above.			
22a. SIGNATURE Ernest Larmore		22b. DATE SIGNED 8/3/67	
22c. PHYSICIAN'S NAME (Type) E. M. LARMORE		22d. ADDRESS Delmar, Del.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8/4/67	23c. NAME OF CEMETERY OR CREMATORY Springhill Mem Gardens	23d. LOCATION (City or Town) (County) (State) Salisbury Sussex Md.
24. FUNERAL DIRECTOR William S. Morand		25a. REC'D BY REGISTRAR DATE AUG 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. Judge	

13

RECEIVED OF DEATH

WISCONSIN

DEPARTMENT OF REVENUE

STATE OF WISCONSIN
DEPARTMENT OF REVENUE
DIVISION OF TAXES

WISCONSIN

E. M. L. L. L. L.

AUG 3 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>1,028 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>Baysinger Trailer Park</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUSSELL JAMES SMALL</u>		4. DATE OF DEATH Month Day Year <u>8 21 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1891</u>
9. AGE (In years last birthday) yrs. <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Groceryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Accomac County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James S. Small</u>		14. MOTHER'S MAIDEN NAME <u>Arentha Marshall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> War I		16. SOCIAL SECURITY NO. <u>213-01-7218</u>	
17. INFORMANT <u>Mrs. Blanche L. Small (Wife)</u> <u>Baysinger Trailer Court, Salisbury, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerotic</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 27, 1964</u> to <u>August 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 21, 1967</u> , and that death occurred at <u>2:15 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>C. H. Winnacott</u>		22b. DATE SIGNED <u>8/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. H. Winnacott, M. D.</u>		22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 23, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>AUG 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11713

CERTIFICATE OF DEATH

11725

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	c. LENGTH OF STAY IN lb <u>2 da.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishopville, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Rural</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Hennie</u> Middle <u>C.</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1921</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u>	9. AGE (In years last birthday) <u>46 yrs.</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Showell, Wor. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Smith, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Mae Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>212-12-3700</u>	
17. INFORMANT <u>Bertha Hall</u>		Address <u>Bishopville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Congestive Heart Failure</u> DUE TO (b) <u>Extreme Obesity and</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Nothing</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>287X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/18</u> , 19 <u>67</u> , to <u>8/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/20</u> , 19 <u>67</u> , and that death occurred at <u>4:45</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Hand J. Silvers</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>8/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Showell Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Showell Wor. Md.</u>
24. FUNERAL DIRECTOR <u>Richard T. Watson</u>		25a. REC'D BY REGISTRAR <u>Selbyville, Del.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 23 1967</u>	

CENTRAL OF MATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

11714		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #1d Film #G393 8/27/67 pb		11726	
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 48 Civic Avenue		d. STREET ADDRESS Civic Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First Smullen Middle Smullen Last		4. DATE OF DEATH August Month 26 Day 19 Year 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1983	9. AGE (In years lost in day) yrs. 83	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, if retired) Lumberman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Worcester Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Charles W. Smullen		14. MOTHER'S MAIDEN NAME Mary Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Elton Moiles, Princess Anne, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH yes yes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) chronic emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July , 19 66 to Aug , 19 67 , that (I) (we) last saw the deceased alive on Aug 26 , 19 67 , and that death occurred at 5 PM , from causes and on the date stated above.					
22a. SIGNATURE John O. Bulkeley		22b. ADDRESS Princess Anne		22c. DATE SIGNED Aug 31 1967	
22d. PHYSICIAN'S NAME (Type)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/29/67		23c. NAME OF CEMETERY OR CREMATORY St. Andrews	
23d. LOCATION (City or Town) (County) Princess Anne, Somerset Co					
24. FUNERAL DIRECTOR James Herman		25a. REC'D BY REGISTRAR DATE AUG 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

Memorandum

To: Director

From: [illegible]

Date: [illegible]

Subject: [illegible]

Re: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

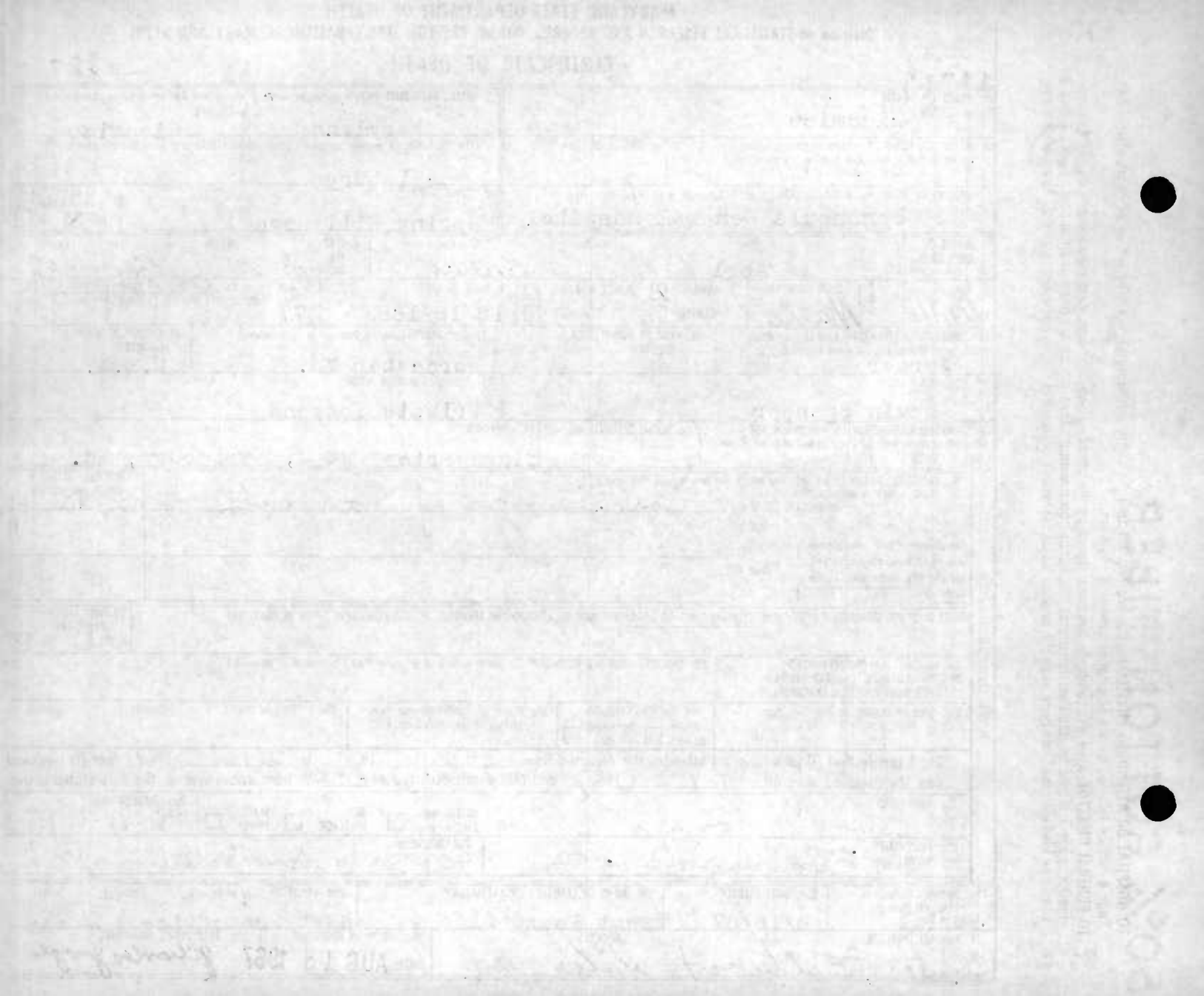
VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11727

11715 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Abel</u> Middle <u>SPENCE</u> Last <u>SPENCE</u>		4. DATE OF DEATH <u>AUGUST 12 19 67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/1889</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Worcester Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levin Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Prissie Townsend</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Clara Price</u>		Address <u>Rt 2, Salisbury, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of Skull</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Within</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , to <u>8-12-67</u> , that (I) (we) lost saw the deceased alive on <u>8-11-67</u> , and that death occurred at <u>4:46 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Earl H. Royer</u>		22b. DATE SIGNED <u>8-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Earl H. Royer</u>		22d. ADDRESS <u>409 Camden Ave. Salisbury Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>West Post Office</u>		23d. LOCATION (City or Town) (County) (State) <u>West Post Office Md.</u>	
24. FUNERAL DIRECTOR <u>Clinton F. Stewart</u>		25a. REC'D BY REGISTRAR <u>Salisbury</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 18 1967</u>	



11716

CERTIFICATE OF DEATH

11728

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>1141 S. Division St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Gilbert</u> Middle <u>JOB</u> Last <u>Steere</u>		4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1918</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bottling Company</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Providence, R. I.</u>
13. FATHER'S NAME <u>Elijah B. Steere</u>		14. MOTHER'S MAIDEN NAME <u>Ernestine Kellerman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes War II</u>		16. SOCIAL SECURITY NO. <u>218-05-8050</u>	17. INFORMANT Address <u>Mrs. Dorothy W. Steere (Wife)</u> <u>1141 S. Division St., Salisbury, Maryland</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>3 mos.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1967</u> to <u>Aug 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 25, 1967</u> , and that death occurred at <u>5 PM</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>David J. Gilmore</u>		22b. DATE SIGNED <u>August 29, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore</u>		22d. ADDRESS <u>Medical Center, Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>August 29, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Walston, Maryland</u>
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>AUG 30 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

11717 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

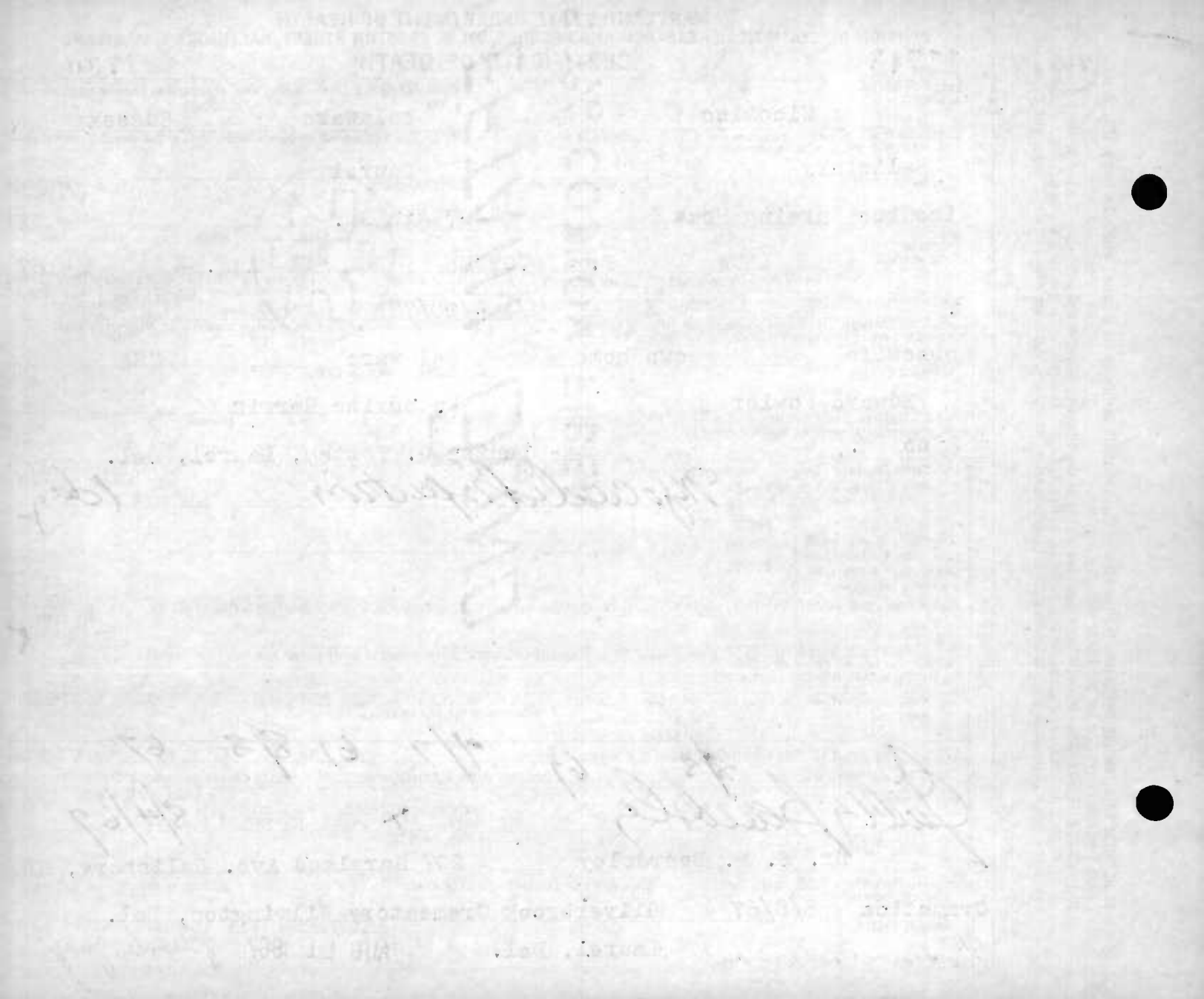
CERTIFICATE OF DEATH

11729

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 19.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Chance	
3. NAME OF DECEASED (Type or print) Norwood Carroll		4. DATE OF DEATH August 29 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 3, 1921
9. AGE (In years last birthday) 46		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Norman Taylor		14. MOTHER'S MAIDEN NAME Blanche Norwood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) War II		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Clyde Taylor		Address Moore Ave, Fruitland Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized atherosclerosis severe (c) ?		INTERVAL BETWEEN ONSET AND DEATH 10 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 19, 1967 to Aug. 19, 1967 , that (I) (we) last saw the deceased alive on Aug 19 1967 , and that death occurred at 3:28 P.M. from causes and on the date stated above.			
22a. SIGNATURE William G. Gay		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 8/31/67	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR James H. Linman		25a. REC'D BY REGISTRAR Princess Anne, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 31 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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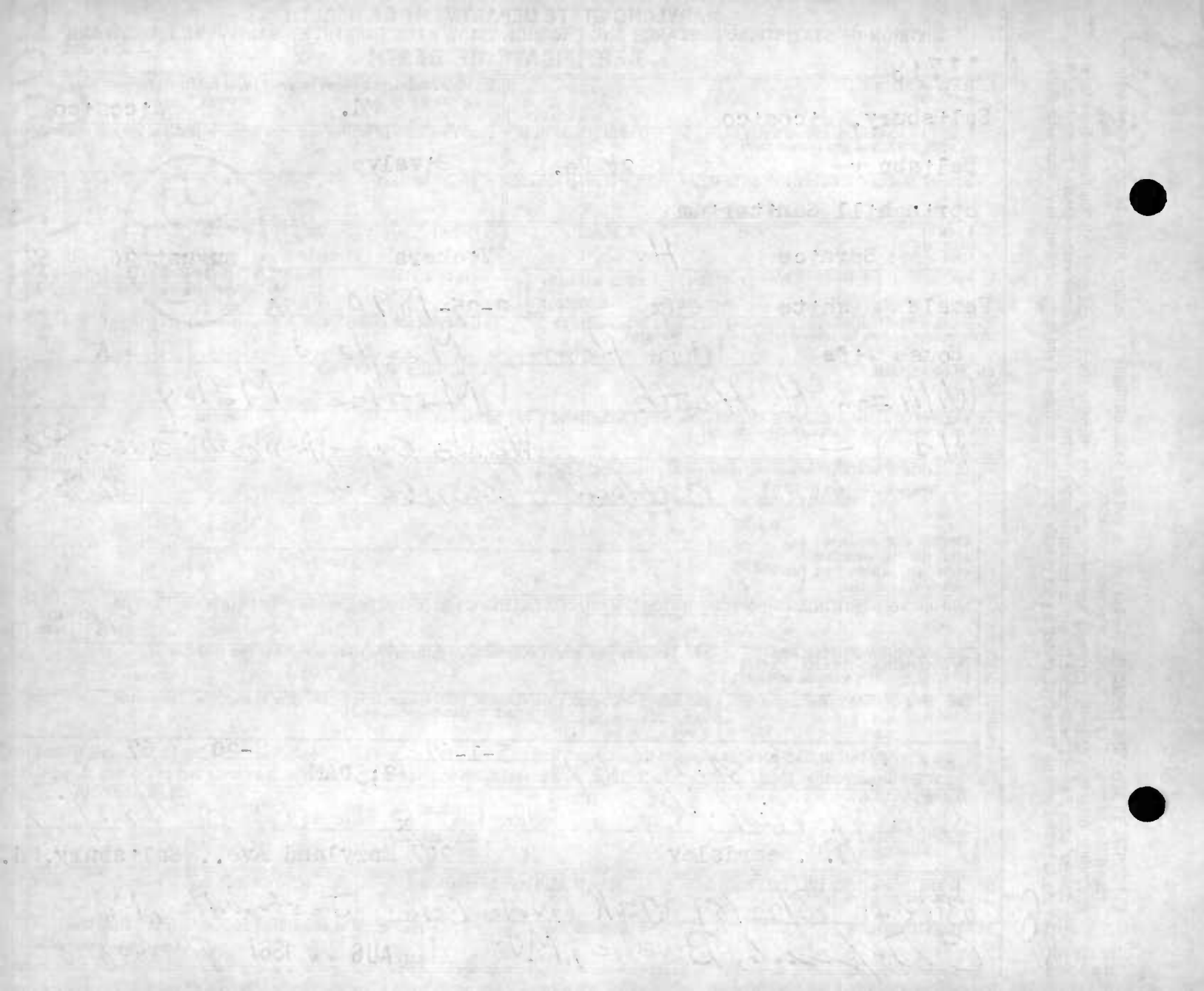
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11718					11730				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			d. STREET ADDRESS <u>407 4th St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wicomico Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>LENA</u>		First <u>F.</u> Middle <u>TOTTEN</u> Last		4. DATE OF DEATH <u>Aug. 4</u>		Month <u>4</u> Day <u>19</u> Year <u>67</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/20/78</u>		9. AGE (In years last birthday) <u>89</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edward Fowler</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Harris</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Louise G. Totten, Laurel, Del.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>4/7</u> , 19 <u>67</u> , to <u>8/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/3</u> , 19 <u>67</u> , and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Dr. E. M. Beardsley</u>					22b. DATE SIGNED <u>8/4/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. M. Beardsley</u>					22d. ADDRESS <u>207 Maryland Ave. Salisbury, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>8/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Silverbrook Crementary Wilmington, Del.</u>		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <u>Wendell Dickerson</u>					ADDRESS <u>Laurel, Del.</u>		25a. REC'D BY REGISTRAR <u>AUG 11 1967</u>		
							25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Salisbury, Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 2 1/2 Mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springhill Sanitarium					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve d. STREET ADDRESS 221 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Bernice			First H.		Middle		Last Vickers		4. DATE OF DEATH Month August Day 20 Year 19 67		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-25-1890		9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME William H. Heath					14. MOTHER'S MAIDEN NAME Matilda Moley						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. —		17. INFORMANT Wanda Cooper, Kenneth Square, Pa. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —										INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 5-1-67 , 19 67 , to 8-20 , 19 67 , that (I) (we) last saw the deceased alive on 8/16/67 , and that death occurred at 2:30 AM from the causes and on the date stated above.											
22a. SIGNATURE E. M. Beardsley					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/22/67				
22c. PHYSICIAN'S NAME (Type) E. M. Beardsley					22d. ADDRESS 207 Maryland Ave., Salisbury, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8/22/67		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem.			23d. LOCATION (City, town or county) (State) Jesterville, Md.			
24. FUNERAL DIRECTOR C. W. Moss, Bivalve, Md.					25a. REC'D BY REGISTRAR DATE AUG 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
11720									
11732									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 307 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital					d. STREET ADDRESS --			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS GORDON WALLS					4. DATE OF DEATH Month Day Year 8 28 1967				
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 7 - 1916		9. AGE (In years lost birthday) yrs. 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Q.A. Co. MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS WALLS					14. MOTHER'S MAIDEN NAME SARAH WATTS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW II			16. SOCIAL SECURITY NO. 579-09-0391		17. INFORMANT Address MRS. HELEN WALLS - CHURCH HILL MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 3320 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Cerebral thrombosis with right hemiplegia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 10 months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from October 25, 1966 , to August 28, 1967 , that (I) (we) last saw the deceased alive on August 28, 1967 , and that death occurred at 1:30 AM , from causes and on the date stated above.									
22a. SIGNATURE C. H. Winnacott					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/28/67		
22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.					22d. ADDRESS Deer's Head State Hospital, Salisbury,				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG. 31		23c. NAME OF CEMETERY OR CREMATORY CHURCH HILL		23d. LOCATION (City or Town) (County) (State) CHURCH HILL MD.			
24. FUNERAL DIRECTOR Alyce R. Lane - CHURCH HILL MD.					25a. REC'D BY REGISTRAR AUG 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

STATEMENT OF DEATH

1. Name of deceased

2. Age

3. Sex

4. Date of death

5. Place of death

6. Cause of death

7. Signature of declarant

8. Signature of witness

9. Signature of physician

10. Signature of registrar

11. Signature of undertaker

12. Signature of funeral home

13. Signature of cemetery

14. Signature of church

15. Signature of family

16. Signature of friends

17. Signature of neighbors

18. Signature of community

19. Signature of state

20. Signature of federal

11721

CERTIFICATE OF DEATH

11733

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>5 WKS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>80 Peninsula General Hospital</u>	
d. STREET ADDRESS <u>509 N. DIVISION STREET.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NINA</u> Middle <u>TAWES</u> Last <u>Webb</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 20, 1893</u>
9. AGE (In years lost birthday) yrs. <u>74</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SOMERSET, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ORRIS L. TAWES</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE WARD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>LUCILLE W. ELZEY,</u>		Address <u>CHESTERTOWN, MARYLAND</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>OBSTRUCTIVE Nephropathy</u> DUE TO (c) <u>Carcinoma of Sigmoid colon</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis with Cerebral Thrombosis.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <u>July 16, 1967</u> to <u>Aug 18, 1967</u> , that (I) (was) last saw the deceased alive on <u>Aug 17, 1967</u> , and that death occurred at <u>7:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill Jr.</u>		22b. DATE SIGNED <u>Aug 18, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL, JR</u>		22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/20/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNNY RIDGE CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>CRISFIELD Som. MD</u>
24. FUNERAL DIRECTOR <u>Franklin Hillf.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 22 1967</u>	
ADDRESS <u>SALISBURY</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11722		CERTIFICATE OF DEATH	
11734			
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>5 Days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u>		d. STREET ADDRESS <u>R. F. D. #2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK.</u> Middle <u>M.</u> Last <u>WEST</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-77</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCK FARM</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WORCESTER, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John West</u>		14. MOTHER'S MAIDEN NAME <u>Mary Chatham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213 22 9653</u>	
17. INFORMANT <u>Preston A. West, Snow Hill, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO (b) <u>arteriosclerotic cardiac vascular disease</u> DUE TO (c) <u>Multiple Myeloma</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u> <u>10 yrs.</u> <u>6 wks.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-12, 1967</u> to <u>8-17, 1967</u> , that (I) (we) last saw the deceased alive on <u>8-17, 1967</u> , and that death occurred at <u>6:30 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Nevins W. Todd, Jr.</u>		22b. DATE SIGNED <u>8-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Nevins W. Todd, Jr.</u>		22d. ADDRESS <u>Medical Center, Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 20, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bates Meth. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Snow Hill, Md.</u>	
24. FUNERAL DIRECTOR <u>Norman F. Gannon, Snow H. H., Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 21 1967</u>	

STATE OF TEXAS

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11723

CERTIFICATE OF DEATH

11735

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb Rural, Princess Anne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 19.2	
3. NAME OF DECEASED (Type or print) First Clarence Middle E. Last White		4. DATE OF DEATH Month August Day 28 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die Maker		11. BIRTHPLACE (County & State, or foreign country) Harrisburg, Pa	
13. FATHER'S NAME John White		14. MOTHER'S MAIDEN NAME Margaret Anne Himmelaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruth White; RFD #1, Princess Anne Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) CARCINOMA LUNG & METASTASIS DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-11 , 19 67 , to 8-28 , 19 67 , that (I) (we) last saw the deceased alive on 8-25 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE James W. Todd		22b. DATE SIGNED 8-28-67	
22c. PHYSICIAN'S NAME (Type) James W. Todd		22d. ADDRESS Med Ctr. Salisbury Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/30/67	23c. NAME OF CEMETERY OR CREMATORY Beechwood	23d. LOCATION (City or Town) (County) (State) Princess Anne; Somerset Co Md.
24. FUNERAL DIRECTOR James L. Herman		25a. REC'D BY REGISTRAR Princess Anne, Md	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 31 1967	

1. Name of the person or organization 2. Address 3. City 4. State 5. Zip		6. Date 7. Time	
8. Subject 9. Description of the event or activity		10. Remarks	
11. Name of the person or organization 12. Address 13. City 14. State 15. Zip		16. Date 17. Time	
18. Subject 19. Description of the event or activity		20. Remarks	
21. Name of the person or organization 22. Address 23. City 24. State 25. Zip		26. Date 27. Time	
28. Subject 29. Description of the event or activity		30. Remarks	
31. Name of the person or organization 32. Address 33. City 34. State 35. Zip		36. Date 37. Time	
38. Subject 39. Description of the event or activity		40. Remarks	
41. Name of the person or organization 42. Address 43. City 44. State 45. Zip		46. Date 47. Time	
48. Subject 49. Description of the event or activity		50. Remarks	
51. Name of the person or organization 52. Address 53. City 54. State 55. Zip		56. Date 57. Time	
58. Subject 59. Description of the event or activity		60. Remarks	
61. Name of the person or organization 62. Address 63. City 64. State 65. Zip		66. Date 67. Time	
68. Subject 69. Description of the event or activity		70. Remarks	
71. Name of the person or organization 72. Address 73. City 74. State 75. Zip		76. Date 77. Time	
78. Subject 79. Description of the event or activity		80. Remarks	
81. Name of the person or organization 82. Address 83. City 84. State 85. Zip		86. Date 87. Time	
88. Subject 89. Description of the event or activity		90. Remarks	
91. Name of the person or organization 92. Address 93. City 94. State 95. Zip		96. Date 97. Time	
98. Subject 99. Description of the event or activity		100. Remarks	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11724					11736				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		Wicomico			a. STATE		b. COUNTY		
		MARYLAND			Maryland		Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Salisbury					Salisbury				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?	
Peninsula General Hospital					Leonard Mill Box 273			YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. AGE (In years last birthday)		
First Middle Last CHARLOTTE --- WHITMYRE					Month Day Year August 1 1967				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		December 16, 1904		62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Housekeeping			---		Baltimore, Maryland			USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
George Lehr					Margaret Kreuder				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address		
No							Miss Marquerite Lehr (Sister) Cartref, Bryn Mawr, Pa. 19010		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>170X</u> DUE TO <u>metastatic C.A.</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>C.A. Rh Blood</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH <u>slightly over 11 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19									
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> 19... to <u>1 Aug</u> 1967, that (I) (we) last saw the deceased alive on <u>1 Aug</u> 1967, and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Earl L. Royer</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED August 2, 1967		
22c. PHYSICIAN'S NAME (Type) Dr. Earl L. Royer					22d. ADDRESS 409 Camden Ave., Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial		August 4, 1967		New Cathedral Cemetery			Baltimore, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR DATE AUG 4 1967				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL INVESTIGATION, U.S. DEPARTMENT OF HEALTH

1. Name of deceased: *John Doe*
 2. Sex: *Male*
 3. Age: *45*
 4. Date of birth: *Jan 1, 1900*
 5. Place of birth: *New York, N.Y.*
 6. Date of death: *Dec 15, 1945*
 7. Place of death: *Home*
 8. Cause of death: *Heart disease*
 9. Manner of death: *Natural*
 10. Signature of physician: *J. Smith*
 11. Signature of registrar: *A. B.*
 12. Signature of informant: *C. D.*

13. Name of informant: *John Doe*
 14. Address of informant: *123 Main St, New York, N.Y.*
 15. Signature of informant: *J. Doe*
 16. Date of completion: *Dec 16, 1945*
 17. Signature of official: *E. F.*
 18. Title of official: *Registrar*
 19. Office of official: *City of New York*
 20. State: *New York*

21. Name of informant: *John Doe*
 22. Address of informant: *123 Main St, New York, N.Y.*
 23. Signature of informant: *J. Doe*
 24. Date of completion: *Dec 16, 1945*
 25. Signature of official: *E. F.*
 26. Title of official: *Registrar*
 27. Office of official: *City of New York*
 28. State: *New York*

4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11725

11737

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 5 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS Willards	
3. NAME OF DECEASED (Type or print) Irma E. Wilkins		4. DATE OF DEATH Month August Day 5 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1893
9. AGE (In years lost 1/4 day) yrs. 74		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James P. Dennis		14. MOTHER'S MAIDEN NAME Margaret Cooper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) xx xx		16. SOCIAL SECURITY NO. 216-10-5951	
17. INFORMANT Hospital Records - Salisbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4222 IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Cardiac embolism.		INTERVAL BETWEEN ONSET AND DEATH Days Yrs Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/1/67 , 19__, to 8/5/67 , 19__, that (I) (we) last saw the deceased alive on 8/5/67 , 19__, and that death occurred at 1:50 PM , from causes and on the date stated above.			
22a. SIGNATURE A. C. Mitchell		22b. DATE SIGNED 8/5/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M.D.		22d. ADDRESS Deer's Head Hosp., Box 2018, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL Willards		23b. DATE THEREOF 8/8/67	
23c. NAME OF CEMETERY OR CREMATORY Willards		23d. LOCATION (City or Town) (County) (State) Willards, Md.	
24. FUNERAL DIRECTOR Peter Whaley, Salisbury, Del.		25a. REC'D BY REGISTRAR DATE AUG 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

Caroline's Father
Antoinette's Heart Dream
Caroline's Mother

✓ 8/2/51

Dr. Reichman

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

11726

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11738

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 46-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA PENINSULA GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle LEE Last WIMBROW		4. DATE OF DEATH Month 8-22-67 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years) 59 yrs.
9. DATE OF BIRTH 9-13-16		10. IF UNDER 1 YEAR Months 59 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Engineer for DPL		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Wimbrow		14. MOTHER'S MAIDEN NAME Anna Mae Wimbrow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 217-10-2328	
17. INFORMANT Katheryn Wimbrow, Dagsboro, Del.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED August 24, 1967	
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md.		22. DATE SIGNED August 24, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8-25-67	
23c. NAME OF CEMETERY OR CREMATORY Carey's Cemetery		23d. LOCATION (City or Town) (County) (State) Millsboro, Sussex, Del	
24. FUNERAL DIRECTOR Watson & Gray Funeral Home, Millsboro, Del.		25a. REC'D BY REGISTRAR SEP 8 1967	
25b. REGISTRAR'S SIGNATURE James J. J...		25c. REGISTRAR'S SIGNATURE	

